DOMESTIC HOMICIDE REVIEW
and
SAFEGUARDING ADULTS REVIEW

EXECUTIVE SUMMARY

Into the death of Doris

in

July 2021

Report Author: Simon Kerss MA, BA (Hons.), PA Dip.
Review Chair: Gaynor Mears OBE, MA, BA (Hons), AASW, Dip SW

Date Completed: October 2024

The following pen portrait and tribute to Doris[1], the victim, has kindly been provided by her daughter:

My mum loved to get things for free. She was born in 1938 in Leeds, the second of two children. She came from a relatively privileged home, but one which knew the value of things. Nothing was just thrown away and everything that could be, was reused. If there is a saying that could capture my mum's approach to things, objects it would be 'mend it or make do'. Meaning, try to fix it but if you can't make do with whatever hash job you end up with.

My mum married young and had four children. My mum was resourceful, she was resilient, and she was skilled. When she and her family moved from suburban Leeds to rural Suffolk in the 1970's, she adapted to her 'little house on the prairie' existence by making almost everything from scratch. She made blackberry wine, the most amazing elderflower champagne, jam, bread, donuts, pickles, she skinned rabbits to make hats and gloves. She learnt how to weave and made rugs. She went to woodworking classes and made tables. Went to pottery class and made pots. She lost many of those skills in later life, but she never stopped trying to create, to make things.

My mum suffered more than her share of loss. She lost her only brother when she was a young mum. I suspect that a part of the reason we moved down south was that my mum was escaping from a desperate grief. She lost my dad in 1994. And whilst their marriage had never been particularly harmonious, it was incredibly close. My dad was quite a character. A proper 'Willy Loman'. He was forever on the brink of making his million in business ventures that only ever resulted in drudgery and debt. His last throw at the dice was a mobile roller-skating rink. This was the only one my mum worked with him on. Whilst he was there at the front, compering, entertaining the kids, having a whale of a time, my mum was in the shadows, quietly, stoically, doing what she did best, maintaining, fixing and quietly making sure that things did not fall apart.

After living various places arounds Suffolk, Benhall, Aldeburgh, Leiston then Felixstowe, it was the roller rink that brought my mum and dad finally to live in Gorleston in 1991. My dad missed Leeds and never really settled down south, but his heart had always been on the stage, and he saw more opportunity for the roller rink to grow in glitzy Great Yarmouth. Sadly, he died a few short years after the move. My mum grieved for many years. She knew no one in Gorleston and felt so lonely. She hated living there and began to pine for Leeds and the friends and family she had left so many years ago. But she had us. Myself and my brother and my two children. So, we created our own family unit, each of us living our own lives but coming together frequently in my mum's house. We would spend every Sunday there, every Christmas, every Easter and Birthday. I was a single mum, and my brother and mum were their family. We raised my children together.

And then everything changed, so gradually it was hard at first to see it. After the fall several years ago in an Asda car park we started to notice changes. There were physical changes, my mum began to suffer bouts of serious dizziness, became reliant on a walking frame. And personality changes, she went from frugal to spendthrift, introvert to extrovert. My mum started to laugh a little more, then she began to find everything funny, then hilariously funny. She started talking to people she didn't know. She trusted other people in a way she never had before. She believed everything she was told.

This new version of my mum wasn't fazed by anything. She was resilient, positive, and very brave. She lost two sons (2016 and 2019), each death struck at her with immense force, but she bounced back quickly. She just went out more, met more people, got more

[1] Pseudonym chosen by the victim's daughter.

involved in their lives, their stories, trying in her way to understand and to help people to feel better.

And quite incredibly she seemed somehow to find life more wonderful than she ever had before. It wasn't because she didn't care for her sons, grief had been chiselling away at her for years, grief was as much a part of her character as that Yorkshire accent she never lost. It was just that she was having such a great time, so much fun, so much interaction and engagement. She was filling every moment so that she didn't have to think about it all. Didn't have to feel.

My mum said to me just a few weeks before she died, that she had never been happier in life. She couldn't really understand the self that she had once been, shy, bothered by other people's judgements and opinions. She felt free and happy. She was determined to live to 100, and she loved her house so very much. Loved her pet seagull, Jeffrey. She loved going to town and getting her goodies (freebies from the food banks), buying her endless hats and coats and blouses from the charity shops. She felt lucky, blessed to have so much. She wanted to give back to other people she saw as less fortunate to help people out. I knew at the time that this was merely the silver lining to a very dark cloud. This joy came at a cost. And it was her eventual meeting with [Chris] that articulated what that cost was exactly.

The Review Panel and members of the Norfolk County Community Safety Board wish to express their sincere condolences to Doris's daughter, grandchildren, great grandchildren, and friends for the untimely loss of one of the most important people in their lives.

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DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

1. The Review Process:

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

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

The victim: Doris, 83 years of age at the time of the homicide.

The victim's daughter: Laura

The perpetrator: Chris,[2] 42 years of age at the time of the homicide.

Both Doris and Chris were of White British ethnicity.

1.3 Criminal proceedings were completed in May 2023, when the perpetrator was convicted of murder and arson. He was sentenced to life imprisonment with a minimum tariff of 35 years.

1.4 The review process began with a Community Safety Partnership decision-making panel[3] on 21 October 2021 and in consultation with partners it was agreed the criteria to hold a domestic homicide review was met. A referral was made by the Partnership to the Norfolk Safeguarding Adults Board (NSAB) in January 2022. In March 2022 it was determined the case met the criteria for a Safeguarding Adults Review (SAR) and a joint review was agreed.

1.5 A total of 11 local agencies were initially contacted to establish which services had been involved or had contact with the parties in this review. Three agencies reported no contact, and 8 confirmed involvement and were asked to secure their files. Following contact with the victim's daughter in March 2022, additional information was sought from an out of county service.

Contributors to the Review

1.6 The following ten agencies provided Independent Management Reviews (IMRs) or reports to the panel:

1.7 The authors of agency Independent Management Reviews (IMRs) were independent of the case, had no management responsibilities for the frontline staff who provided services to the parties involved, nor did they have personal contact with the parties to this review.

1.8 Family members also contributed to this Review.

The Review Panel Members

1.9 Panel members had no line management of staff involved in this case, nor had they had any contact with the parties involved. The following were members of the Panel undertaking this review:

[2] Chris is the pseudonym chosen for this review by the DHR Chair and Author after checking with the victim's family that it had no relevant connotations within their family. Other pseudonyms were chosen by the victim's family.

[3] The Norfolk County Community Safety Partnership has a standing 'Gold Group' which meets to make the decision as to whether the circumstances of a fatal incident meet the criteria for a DHR to be undertaken. This multi-agency group includes the specialist domestic abuse voluntary sector in its membership.

Name	Agency Represented	Job Title
Gaynor Mears	Independent Chair	
Simon Kerss	Independent Author	
Amanda Murr	Office of the Police & Crime Commissioner for Norfolk	Assistant Director Policy & Partnerships
Liam Bannon	Office of the Police & Crime Commissioner for Norfolk	Community Safety Manager
Nicola Allum	Office of the Police & Crime Commissioner for Norfolk Community Safety Officer	Community Safety Officer
DCI Stacey Murray then DCI Matthew Stuart	Norfolk Constabulary	DCI Safeguarding & Investigations
DI Chris Burgess[4]	Norfolk Constabulary	Senior Investigating Officer
Vicky Aitken	Age UK	Head of Operations, Age UK Norfolk
Walter Lloyd-Smith	Norfolk Adult Safeguarding Board	Safeguarding Board Manager
Helen Thacker	Norfolk County Council Adult Social Services	Head of Service for Safeguarding
Kristal Oakley	Norfolk Integrated Domestic Abuse Service (NIDAS)	Senior Independent Domestic Violence Advisor
Henry Griffiths / Jennifer Chenoufi	Suffolk Probation Service	Head of Suffolk Probation Services / Senior Probation Officer
Paula Boyce	Great Yarmouth Borough Council	Strategic Director
Nichola Bennett	Suffolk County Council	Adult Safeguarding Operational Manager
Matthew Armitage	Change, Grow, Live[5]	Deputy Service Manager
Saranna Burgess (3 Panels) then Christine Hodby (2 Panels)	Norfolk and Suffolk NHS Foundation Trust (Mental Health)	Director for Patient Safety & Quality, Patient Safety Specialist / Director for Patient Safety and Safeguarding
Dr Sunder Gopaul	Local Medical Practice	GP
Gary Woodward	Norfolk and Waveney Integrated Care Board	Designated Lead Professional Safeguarding
Melanie Yolland	Suffolk County Council Community Safety Partnership	Community Safety Officer
Dr Abu Sathyanarayanan	Local Medical Practice	GP
Sue Marshall / Nadia Jones	Norfolk County Council CES Public Health	Safeguarding and Partnership Manager
Kelly Boyce / Eleanor Elder	James Paget Hospital	Head of Safeguarding Named Nurse Safeguarding Children & Adults
Elaine Joyce	East of England Ambulance Service NHS Trust	Sector Safeguarding and Lead Named Professional

[4] Two meetings only to update the Panel.

[5] Change Grow Live is a voluntary sector provider of services to those affected by substance misuse. The service aims to help people change the direction of their lives, grow as individuals, and live life to its full potential. See: https://www.changegrowlive.org/

The Chair of the Overview Report

1.10 The Review chair is independent consultant Gaynor Mears OBE. The author holds a master's degree in Professional Child Care Practice (Child Protection) during which she made a particular study of domestic abuse, its impact, the efficacy of multi-agency working and the community coordinated response to domestic abuse. Gaynor holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification. It was her experiences of cases of domestic abuse as a Children and Families Team senior practitioner which led her to specialise in this subject.

1.11 Gaynor has extensive experience of working in the domestic abuse field both in practice and strategically, with roles at county and regional level, and national level for the Home Office. She has experience in undertaking Domestic Homicide Reviews from their implementation in 2011, and research and evaluations of domestic abuse services. Gaynor has experience of working in crime reduction as a community safety manager; with Community Safety Partnerships; and across a wide variety of agencies, both in the statutory and voluntary sector. She has also served as a trustee of a charity delivering a Respect accredited community perpetrator programme. Gaynor has no previous connections with any agency in Norfolk, other than as a previous chair and author of DHRs for the Norfolk County Community Safety Partnership.

The Author of the Overview Report

1.12 As the country's first male Domestic Violence Coordinator (later, Domestic Abuse and Sexual Violence Partnership Manager), Simon Kerss was responsible for developing and implementing several countywide, multi-agency strategies and associated action plans over the course of a decade in Cambridgeshire and Peterborough. This role involved coordinating and embedding activities such the DASH Risk Assessment, MARAC, IDVAS, ISVAS, and DHRs (including piloting the process for the Home Office in 2010) within local services, and undertaking four countywide, multi-agency needs assessments.

1.13 Simon is an Honorary Fellow with the Policing Institute for the Eastern Region (PIER) where he specialises in evaluating agency responses to Violence Against Women and Girls (VAWG) and other forms of Serious Violence / Crime. Prior to this, he was a lecturer in criminology at Anglia Ruskin University (ARU), Cambridge for 8 years. Simon remains an Associate Lecturer with ARU at the present time. Simon has recently co-authored the national Ministry of Justice evaluation of MAPPA Serious Case Reviews with PIER/VKPP and is the independent Chair of Cambridgeshire Constabulary's Out of Court Disposal Scrutiny Panel.

1.14 Full details of the chair and author can be found in the Review Overview Report. Both the chair and author meet the requirements for a DHR author and/or chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of training, and the experience required.

Terms of Reference for the Review

1.15 The purpose of the Review is to:

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

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

Specific Terms of Reference for the Review:

1. The review will identify and examine in detail agency contact with the victim and the perpetrator between the Spring of 2020, when the perpetrator is understood to have met the victim, and July 2021. Agencies that had contact with the parties involved and their family members before that date are to give a summary of their involvement to provide background history and context to events.

2. Under the Care Act 2014 which came into force in April 2015 the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

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

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

3. Did Doris, close family members, or anyone else ever express concerns about her safety, or the alleged perpetrator being in her home to anyone, what was done with the information, and what action was taken?

4. What risk assessment tool or checklist did services in contact with the victim or alleged perpetrator undertake in the course of their involvement and what actions did these risk assessment trigger? Including the following:

a) Was the risk assessment fully informed by an assessment of the victim in person, her home environment, and consideration of the alleged perpetrator who was known to be living in her home at the time?
b) Was the risk assessment reviewed and updated in response to changing situations or information?
c) Were any patterns of abuse considered in assessing the level of risk to the victim. For example, did repeat incidents or referrals from other agencies result in a higher assessment of risk. If not, why not? And was a Multi-Agency Risk Assessment Conference (MARAC) referral considered on the basis of repeat victimisation or professional judgement? *and what actions did these risk assessment trigger?*
d) Did risk assessment include and consider the criminal history and substance misuse of the alleged perpetrator?
e) Do practitioners using the risk assessment tool believe it is fit for their purposes or are there aspects which could be improved to assist them in assessing risk in adult family abuse or elder domestic abuse cases?

5. Did agencies in contact with the victim and perpetrator consider the impact of coercive and controlling behaviours on the victim's presentation to agencies, and were the principles of safe inquiry followed when contacting Doris?[6]

[6] For guidance on safe enquiry, please see: Local Government Association, 2015. *Adult Safeguarding and Domestic Abuse*, pg.38. adult-safeguarding-and-do-cfe.pdf (local.gov.uk)

6. Was Doris's mental capacity assessed? If so, how was this undertaken and by whom? Was the assessment compliant with the Mental Capacity Act 2005 and its Code of Practice. Did capacity assessments include:

a) dementia assessment
b) a distinction between decisional and executive capacity
c) any potential impact of coercion on capacity.

7. If capacity assessments were completed, how and in what ways did these assessments inform any actions taken. Were Doris's wishes and feelings taken into account and considered as part of these capacity assessments. In reflecting making safeguarding personal how were Doris's wishes and feelings understood in relation to any known risks to her safety. What actions did these capacity assessments trigger?

8. If Doris was found to be capacitous for the decision for the alleged perpetrator to remain in the home was invoking 'inherent jurisdiction'[7] considered as an option to safeguard Doris from her abuser?

9. When assessing care and support needs, was consideration given to the views of friends and/or family of the victim and:

a) changes over time that may have been indicative of cognitive difficulties not captured in conversations
b) observations in all the different domains of everyday living, including for example the management of finances, self- neglect
c) health records; including a head injury following a fall
d) the impact of bereavement.

10. If it was the case that incidents involving either Doris and the perpetrator were dealt with in isolation by agencies, what barriers prevented agencies working together in a more holistic way? What changes can be made to better support and encourage work across agencies in order to better protect an adult at risk?

11. Had the individual practitioners in contact with Doris and the alleged perpetrator, or those involved in decision making about safeguarding, undertaken the following training:

a) Domestic abuse training (state duration and content of the training)
b) Adult family violence domestic abuse training (state the duration and content of this training)
c) Types of domestic abuse including coercive control, financial/economic abuse, risk assessment tools, and referral to MARAC and/or other specialist support services
d) Trauma informed practice
e) Do the practitioners believe the level of training was sufficient to give them the skills they need to identify adult family abuse, and how to address the abuse of adults in the context of domestic abuse? If not, identify the practitioner's gaps in their training needs?
f) Were there conceptual barriers which prevented agencies identifying the circumstances of the relationship between Doris and the alleged perpetrator as domestic abuse?

12. What was done to manage the perpetrator's breach of Covid restrictions given that this may have put Doris at additional risk given her vulnerability due to health issues? And what was the impact of Covid 19 and the restrictions put in place by the government from March

[7] Mental-Capacity-Guidance-Note-Inherent-Jurisdiction-November-2020.pdf

2020 onwards[8] on service provision and the ability of services to support vulnerable members of society such as Doris?

13. All Individual Management Reviews (IMRs) must include analysis of whether questions asked in phone calls, interviews or assessments were sufficiently probing, used open questions to give the victim sufficient opportunity to describe her experiences and feelings, and demonstrated professional curiosity to identify abuse, or coercive and/or controlling behaviour towards her.

14. Considering the temporal scope of the review, were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? This includes caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.

15. Were the actions or information sharing by those involved with either Doris or the perpetrator affected by General Data Protection Regulation (GDPR) duties and were the caveats which enable information sharing to take place understood and acted upon to safeguard their welfare?

16. What background information about previous callouts and the perpetrator's history did officers have when enroute to callouts at the victim's address to assist them in assessing the situation? Was the perpetrator's previous criminal history shared in onward referrals to partner agencies?

17. Was consideration given to formally disclosing the perpetrator's criminal history to Doris to assist in reducing the risk he posed to her?

18. Did the Probation Service provide the courts with all necessary information to enable the court to make decisions regarding the most effective and appropriate sentencing decisions in light of his history and regular breach of existing orders in place?

19. Was management and supervision of the perpetrator sufficiently robust, in line with probation procedures, and did this include investigation of where he was living, a home visit, and the suitability of that address given the presence of a vulnerable elderly woman and his criminal history?

20. Were the police informed of the perpetrator's supervision by the Probation Service and the orders to which he was subject? If not, why not?

21. If the police were informed of the Probation Service's involvement with the perpetrator did they report the incidents to which they were called involving the perpetrator to Probation to inform his offender manager? If so, what was the outcome?

2. Summary Chronology:

2.1 Agencies first became aware that Chris was living in Doris's home on 11 June 2020 when Police records state 'Chris is friendly with an elderly female called Doris, (area where she lived was noted) and she has offered him to stay at [sic] his'. This unsourced record

[8] First national lockdown (March to June 2020), Minimal lockdown restrictions (July to September 2020). Reimposing restrictions (September to October 2020), Second national lockdown (November 2020), Reintroducing a tiered system (December 2020), Third national lockdown (January to March 2021), phased exit from lockdown (March to July 2021). For details see: Coronavirus: A history of English lockdown laws - House of Commons Library (parliament.uk)

concludes with 'NFI' (no further information). Further records on 19 June and 3 July confirm this information, stating that Chris was residing in Doris's shed with her permission.

2.2 Also on 11 June 2020, the Probation Service recorded Chris failed to attend a telephone appointment. He also failed to attend Probation telephone interviews on 1 July and 8 July. However, Chris did appear at Great Yarmouth Magistrate's Court on 8 July where he was charged with 3 counts of contravening Covid lockdown requirements and of being a pedlar without a certificate. All matters were adjourned until 2 October 2020.

2.3 Doris first engaged with a local debt management charity, StepChange, in March 2018 for support to address debts related to home improvements. It is known that her grandson, Jack, was helping Doris to manage her finances at this time. An assessment by StepChange on 17 June 2020 recorded Doris's issues with mobility. Doris's daughter, Laura, called the charity on Doris's behalf on 29 June 2020 to advise that she [Doris] was suffering financial abuse from Chris.

2.4 On 20, 21, 23, and 25 June, Chris attended James Paget University Hospital (JPUH) for treatment relating to an alleged assault on him some days prior. Chris was referred for further treatment to the ENT (Ear, Nose and Throat) Clinic where he disclosed taking Methadone[9] and drinking 1 litre of gin or port a day. He was discharged from JPUH on 25 June 2020.

2.5 Chris failed to keep appointments with Probation on 15 and 22 July 2020. He also failed to attend a scheduled appearance at Great Yarmouth Magistrate's Court on 29 July for an alleged offence of common assault. However, on 30 July, Chris did attend a hearing at Norwich Magistrate's Court for a breach of a community order and for the alleged offence of common assault. His case was adjourned to 16 September 2020.

2.6 Norfolk Police first attended Doris's home on 5 August 2020, following concerns raised by Laura about the appropriateness of Chris having taken up residence there. Laura told Police she was concerned Doris was suffering from early onset dementia and could 'lack capacity'. Information from Laura included that her mother told her Chris was frequently drunk and 'will then act strangely as pretends he is a dog and will walk around naked'. Laura also advised Police her mother had told her 'several months ago' that Chris 'would touch himself over his clothing in front of her' and since moving into Doris's home they had been in a sexual relationship with one another and were planning to marry – after which Doris would 'leave him the house'. When Police spoke with Doris, she told them she had 'previously kicked Chris out as he walked around naked, and she didn't like that'. The same record states Doris told officers that 'he wouldn't dare touch her and she would not allow that'. At the time of the Police visit, Chris removed himself to a different room in Doris's home and began playing the piano and 'singing at the top of his voice'. Following their attendance, Police shared this information with the local Multi-Agency Safeguarding Hub (MASH) via an Adult Risk Assessment.

2.7 Chris failed to attend scheduled telephone appointments with Probation on 5 and 12 August 2020.

[9] Methadone is a man-made opioid (also known as an opiate). Methadone is used to help patients stop taking heroin. It reduces withdrawal symptoms, such as shaking, shivering and other flu-like symptoms. It also helps stop cravings. See: https://www.nhs.uk/medicines/methadone/#:~:text=Methadone%20is%20a%20man%2Dmade,and%20other%20flu%2Dlike%20symptoms.

2.8 As a result of the Police contact with MASH on 5 August 2020, a practitioner from the Social Care Community Engagement team (SCCE) contacted Doris, by phone. The practitioner at this time recorded that Doris appeared to have capacity, no care and support needs, and Doris's daughter and granddaughter were in regular contact with her. Subsequently, Doris was encouraged to have Chris contact his GP regarding his alcohol misuse and also for Chris to engage with Great Yarmouth Borough Council to address his accommodation needs.

2.9 Laura called Police again on 16 August; Chris had been 'shouting at Doris' and she no longer wanted him staying with her. This record shows Doris had left Chris's belongings outside her home, and she 'believed he had headed to the beach'. No further action was taken by Police as a consequence of this information.

2.10 Chris called 111 on 29 August 2020 claiming he was having a heart attack. He attended JPUH on 30 August with self-harm injuries to his arm which required sutures. During this visit, Chris stated he had 'fought with a woman he was living with' and disclosed his issues with alcohol abuse and intravenous drug use. Chris was seen by the mental health liaison team but was 'deemed not to have a mental illness'. Records show Chris discharged himself on this date, and Police were called by JPUH staff to undertake a welfare check with him. On 3 September, Chris again attended JPUH for a blood test prior to being discharged.

2.11 Doris's grandson Jack contacted Police on 1 September 2020 to raise further concerns about Chris's presence in Doris's home. Records show Police called Doris the following day and gave 'safeguarding advice' to her before making a 'safeguarding contact' with the MASH on 6 September. This contact was responded to by a SCCE practitioner, who called Doris the same day. The SCCE practitioner asked Doris if she needed the support of Social Services to remove Chris from her home to which Doris is recorded as saying "yes please". Doris was then asked whether she required support with any daily tasks but said "no" and that she was fit and healthy and enjoyed gardening. The SCCE practitioner sought Doris's consent to contact her daughter (Laura), and this was agreed by Doris. The SCCE practitioner then agreed to call Doris back within 2 days, after they had spoken to the Safeguarding Team.

2.12 The SCCE practitioner called Laura the same day (6 September). Laura advised her mother had recently lost her two sons and had started befriending individuals with 'social and mental health issues' to compensate for her grief. Laura said one of Doris's sons had acted as her carer and provided a great deal of emotional support and companionship. Laura also stated her mother's personality had 'changed over recent years' and this was possibly due to 'underlying mental health issues or dementia'. It is recorded that Laura also reported she felt that Doris may have undiagnosed Emotionally Unstable Personality Disorder, and Doris had 'always had poor emotional regulation and has a history of being very verbally aggressive'. Laura added that Doris 'needs to have control over people close to her and she needs someone to be dependent on her'. During this call, Laura reiterated her concerns regarding the sexual nature of the relationship between her mother and Chris, and that he was an alcoholic and heroin addict. She also stated there were frequent verbal arguments between Doris and Chris, and the Police had attended these. Laura felt Chris had 'embedded himself and taken over the house' – a behaviour which she claimed Police had described to her as 'freeloading' (not reflected in Police records), and in-keeping with Chris's previous behaviours. Laura further advised the Police had told her about a prior incident where Chris had 'thrown urine over someone's head' and Chris does not 'respect social distancing as he believes the Covid pandemic is a lie'. During the conversation, Laura reflected that her mother was 'benefitting from the companionship' with Chris, but the situation was 'explosive' and had the potential to 'go very wrong' as Doris may 'push' Chris to turn on her and harm her'. Laura cast doubt on Chris's claim to have housing-related appointments with GYBC

and requested an assessment of her mother's mental capacity, as she was 'making decisions she would never have made a few years ago and does not seem to understand the risks of the situation with Chris.' SCCE records show that Laura said Doris was able to manage all of her daily tasks independently and had actually become more independent since her sons had died. However, Laura also reported she had some concerns that Doris was not taking her medication correctly, so had called Doris's surgery. As a consequence, a nurse had called Doris and then told Laura that she [the nurse] had no concerns around Doris's mental capacity or ability to manage her medication. The SCCE practitioner advised Laura that Doris did 'not have the appearance of need for social care' and was unsure whether there was anything ASSD could do to support her. The SCCE action arising from this telephone call with Laura was for the practitioner to discuss it with a Safeguarding Adults Practice Consultant (SAPC) and to call Laura back.

2.13 The SCCE practitioner contacted Doris's GP later on 6 September and was told Doris had no diagnosis relating to 'any cognitive impairment' or 'condition that could affect her decision-making ability and mental capacity. The GP further advised that they had 'no concerns on record about her [Doris's] mental capacity'.

2.14 Laura made further contact with the SCCE practitioner on 14 September to report that Chris had gone to GYBC and was 'apparently on a waiting list for accommodation'. During this telephone conversation, Laura asked if she should share her concerns with GYBC regarding Chris's behaviour. The records state that Laura was advised to first seek her mother's consent to share this information. Laura raised further concerns regarding her mother's behaviour and advised that there had been 'a significant shift in her character' which may be due to onset of dementia impacting on her capacity to make decisions. The action for SCCE arising from this contact with Laura was for the SCCE practitioner to discuss the case with MASH and provide feedback to Laura as a consequence. During the conversation between the practitioner and MASH Safeguarding Adults Practice Consultant (SAPC), the SCCE practitioner was advised to call Doris to establish whether she could recall details of the conversation between her and SCCE the previous week, and in doing so better determine whether she had mental capacity around her social care needs. The SCCE practitioner was also encouraged to remind Doris of the 'risks of Chris being there'.

2.15 The SCCE practitioner called Doris on 16 September who said she could not remember speaking with the practitioner the previous week. The SCCE practitioner outlined the concerns raised by Police and Doris's family and again asked if she needed support in getting Chris to leave. The records state Doris declined support with removing Chris from her home, and she planned to tell him that her family didn't like him [Chris] and he should go as she was concerned her family would not visit for Christmas if he was still there. When asked about Chris, Doris replied she never intended for Chris to live with her, and this was just 'the odd night' at first. Doris confirmed she would not do it again, she had 'learned her lesson' regarding inviting strangers to stay in her home, and she liked living alone. At the conclusion of this call, the SCCE practitioner advised Doris that if she had a change of mind, she could contact ASSD 'at any point'. The action arising from this intervention was for the SCCE practitioner to contact the MASH SAPC for 'further consultation'. On the same day as the SCCE telephone call with Doris, a male individual called SCCE from Doris's telephone to ask whether 'this was social services?'. When the SCCE practitioner advised it was, the male hung up. SCCE records show that the practitioner believed this caller to be Chris.

2.16 Later on 16 September 2020, Doris called Adult Social Care and advised she did not want Chris living with her. The record states there was an open safeguarding record on her file for the same issue, but no further actions were undertaken as a consequence of the call.

Probation records for the same date (16 September) show that Chris appeared at Great Yarmouth Magistrates' Court for a breach of his community order. This case was adjourned until 2 October 2020 for sentencing.

2.17 On 17 September, Doris called SCCE to report that Chris had become 'particularly drunk last night' and she was worried about him damaging her television as he 'was waving a long stick about.' Doris stated she had asked Chris to leave and would like help with this. Records show the SCCE practitioner advised Doris to seek help from her family to remove Chris from her home, but Doris said this would not happen as her family were scared of him. The SCCE practitioner then advised Doris to contact the Police for support, and Chris should contact GYBC regarding housing. Doris did call Police as advised that day. She told Police she 'didn't want him [Chris] living in her house anymore,' and when she had told him she had contacted GYBC about his housing situation, Chris became 'very shouty' and said he 'wasn't going anywhere'. Officers attended Doris's home as a result of this call and asked Chris to leave the address at Doris's request. A CAD (Computer Aided Dispatch) marker was placed on the address, and records updated to reflect this. By 21 September, however, Police records state Chris was once again living with Doris and that her family 'are unhappy with her taking him back in.'

2.18 On 22 September, a SCCE practitioner discussed Doris's case with the MASH SAPC during which it was agreed Doris had capacity 'around the Care Act outcomes' and there was 'no role for safeguarding at this stage'. Actions arising were to advise the Police the case would be closed; feedback would be given to Doris's daughter; and Chris would be contacted to ascertain whether he required any support from ASSD. When the SCCE practitioner called Laura, she [Laura] 'disputed' the decision and requested a Care Act assessment for her mother. Laura advised that her mother had been falling victim to financial 'scams' and she would be 'lost without help' and she reported her mother was afraid of Chris when he was drunk and would often lock herself in her bedroom to avoid him. She stated her mother would forget why she had called the Police when she was fearful of Chris, and Doris wanted him out of her house. Regarding the incident attended by Police on 17 September, Laura advised SCCE that Chris 'started hysterically screaming "c***"' at Doris as a result of her contact with GYBC (this was not recorded by Police), and Doris had allowed Chris back into her home as she [Doris] had forgotten why she was scared of him. Laura also advised SCCE she and her children were scared of Chris, and she felt he posed a serious risk to her mother as he could not control his emotions and he was 'dangerous'. During this conversation, Laura told the SCCE practitioner that she feared Chris would kill her mother and 'whether ASSD would stand by their actions in a Safeguarding Adults Review.'

2.19 Following further discussion between the SCCE practitioner and the MASH SAPC, also on 22 September 2020, the practitioner was advised to contact Doris regarding Laura's allegations against Chris. Following this discussion, the SCCE practitioner called Doris and asked if she was alone. Doris replied that Chris was present, but that she would go into another room. The SCCE practitioner recorded that he could hear Chris in the background saying, 'don't talk about me please, you don't have permission to talk about me.' When asked about the incident of verbal abuse, Doris denied that Chris had been abusive towards her, and his foul language was directed at the person she was speaking to on the phone. Doris further stated she 'wasn't scared of him [Chris]. I never am', but she wanted him to get a flat of his own otherwise her family wouldn't visit for Christmas. Doris then handed the phone to Chris so the SCCE practitioner could discuss her referral to ASSD for him.

2.20 Another call was made to Doris on 22 September by an Adult Social Care Assistant Practitioner (AP) to discuss Laura's allegations and Doris's contact with ASC around Chris's

accommodation needs. Doris told the AP that she would like Chris to have left her home by Christmas. Chris told the AP he was able to undertake his own tasks and 'does not have any disabilities'. Chris further stated he had previously declined support from his GP, though there are no GP records to back up this statement, and he felt he had 'no mental health issues whatsoever'. As a consequence, the AP provided Chris with the Adult Social Care telephone number and advised him to call if he needed support and the referral for him was closed following discussion between the AP and a Practice Consultant.

2.21 On 23 September, Laura received a call from the SCCE practitioner with an update. The practitioner advised Doris had appeared 'very upset' at the suggestion that she may need a Care Act assessment. Laura advised the SCCE practitioner that her mother did 'benefit' from Chris's presence, but her mother was 'not retaining contextual memory' of how she felt when things were bad. Laura further stated Chris was 'knowingly taking advantage' of Doris, and Doris did not have capacity to make decisions regarding the risks to her. The SCCE practitioner advised Laura that they would discuss the case further with their manager and call her back. On the same day Doris also called the SCCE practitioner to report she felt her 'daughter was acting unreasonably towards Chris, she wants me to cut him out'. The SCCE practitioner challenged this and advised Doris that she had stated she wanted Chris out of the house during their last telephone conversation. To this, Doris stated 'I do want him out, but I want to stay friends with him'. The SCCE practitioner advised this scenario was possible but was best done 'outside the home so she can maintain social distancing'. The records show Doris thought her daughter assumed she was lonely, but this was not the case. Doris added she did not think she required a Care Act assessment but did then agree to this assessment taking place. On the same day, SCCE received a Police Safeguarding Referral Form (at 'medium' risk level) regarding concerns for Doris and Chris's behaviour. When this referral was discussed by the SCCE practitioner with the MASH SAPC, it was decided a Section 42 Safeguarding Enquiry would not be raised, as there 'there was not enough evidence of abuse or care and support needs.' Instead, the case was to be transferred to the Eastern Locality Team for a Care Act assessment to establish Doris's care and support needs and to understand whether Doris had mental capacity relating to these. Laura was updated, and the following day, 24 September 2020, Doris's case was sent to the locality team, was triaged with the decision to 'allocate for a visit rather than complete a duty visit' and allocated to a social worker on 25 September. On 28 September, the allocated social worker called Doris, but received no reply.

2.22 A friend of Doris's called Police on 2 October with concerns about Chris. On attendance, officers spoke with Doris and Chris separately. Doris told officers she was happy for Chris to continue to live with her, but that she wanted him to move out before Christmas. Both Chris and Doris told officers that Chris was paying Doris £40 per week in rent. Doris told officers she had seen Chris become 'aggressive, abusive and intimidating' to other people, but he had never behaved in this way towards her (the record notes this statement conflicted with previous statements made by Doris). Police listed concerns for Doris regarding this attendance as 'vulnerable due to her age, generosity and naivety' and Doris intended to give Chris her valuable piano once he had moved out. The Police record states officers had spoken with Doris's daughter, Laura, the same day and she had advised her mother was negatively impacted by the loss of her two sons, one of whom shared similar characteristics to Chris and was Doris's carer before his death. Laura stated she believed her mother was in the early stages of Alzheimer's, but she had not seen her GP regarding this. Laura also reported to officers she felt her mother's personality and behaviours had changed, and activities such as trying to win money from advertisements or talking about 'things of a sexual nature' were unusual for her. The Police record states Laura told officers Doris had disclosed to her that she and Chris were in a sexual relationship and Chris had touched himself in front

of Doris. Probation records, also for 2 October 2020, state Chris attended Great Yarmouth Magistrates' Court for a breach of a Community Order. This hearing was adjourned until 12 March 2021 to 'tie up with other matters.'

2.23 SCCE received a third contact from MASH Police outlining concerns for Doris on 3 October following contact with one of Doris's friends. Additional notes linked to this email stated a 'Police referral attached to LAS contact record' and officers spoke at length to Doris who 'was clear that she had no concerns' and 'appeared happy and did not disclose any concerns for her living situation'. In response to this contact, the allocated social worker replied, via email, on 5 October advising Doris had been spoken to, 'she retains mental capacity', and did not 'express any concerns in relation to potential financial abuse'. The email concluded the 'family may be concerned but… [Doris] is allowed to make possible unwise choices' and no further action would be taken as a result of the Police notification. The same day an email was sent from the East Locality Team to Police at MASH advising that Doris's case would be closed to the social worker and re-allocated to East Older People / Physical Disability Reviews South.

2.24 On 8 October, a friend of Doris's told Police Chris had made a threat to 'stick a plastic bag over [Doris's friend's] head' and throttle her. This event was linked to an incident where the friend had called Police to attend Doris's home following concerns about her welfare relating to Chris's presence in her home. Police took no further action following this call out, as there was no further complaint from the victim (Doris's friend).

2.25 Doris called Police again on 3 November 2020 reporting that bailiffs were at her door with a warrant to take payment or goods relating to Chris's debts totalling £380. The record states Chris was becoming obstructive and could be heard shouting in the background and Doris was distressed and crying. The record further states Chris was 'spoken to', but it is not clear whether this was by Police or by the bailiffs. Chris said he did not have the money, that he was homeless and not residing at Doris's home. The record concluded by recording 'situation becoming heated; officers to attend for BOP [Breach of the Peace]'. Police notes attached to this record state Chris had left Doris's home prior to their arrival but had 'told the Courts' that he was not resident at Doris's address. Officers at this time advised Doris 'not to let Chris return and to call Police if he did.'

2.26 On 12 November, Chris appeared at Great Yarmouth Magistrates' Court relating to prior charges which had been carried over from earlier hearings. Further offences of assault by beating, assault by beating of an emergency worker, resisting arrest, and using threatening / abusive words / behaviour likely to cause harassment, alarm or distress (x 6), criminal damage, failure to comply with a community protection notice, common assault, and breach of a Community Order were also to be heard at this time. Chris was remanded on Conditional Bail until 8 March 2021, with the exclusion condition not to contact directly or indirectly one of the women he was accused of assaulting to 'prevent interference with witnesses or otherwise obstruct the course of justice.'

2.27 Doris's case was allocated to an East Locality AP on 16 November but was closed the same day. The note attached to this record states 'at this stage the original request from SCCE (on the basis of the SAPC consultation 23 September) for face-to-face Care Act assessment and MCA appears to have been closed down.'

2.28 Doris called an ambulance for Chris on 4 December 2020 after he had fallen whilst drunk. On attendance at James Paget University Hospital (JPUH), Chris's notes record he had suffered a seizure 'likely due to alcohol withdrawal'. Chris self-discharged 'against medical

advice'. He attended JPUH again on 20 December for a 'Doppler'[10] ultrasound test, however, he refused to wear a face covering and discharged himself.

2.29 Police were called by Doris again on 12 January 2021, to a 'verbal argument' with Chris at her home. During this incident, Doris had called 999 but Chris had twisted her finger to stop her. Police recorded 'no injury' and Doris did 'not wish to make a complaint about this.' Chris was recorded as being 'very anti-Police' during this incident. Officers found 4 syringes with bent needles attached under the chair Chris was sitting on during their visit. He claimed these were to clear his ears out and produced a calendar to show that he had attended an 'ear appointment' the previous day (11 January).

2.30 On 26 January 2021, Chris contact PALS[11] with regards to a cancelled appointment at JPUH. He was told his blood test appointment had been cancelled as he had refused to wear a face covering and had become 'verbally abusive and confrontational in his manner towards staff' at his previous appointment. Chris made a further complaint to JPUH on 22 February and made an abusive call to the hospital on 1 April. Two more complaints from Chris were received by JPUH in the month of April, in addition to a Freedom of Information (FOI) request. Further complaints from Chris were forthcoming throughout April and May. Staff at JPUH responded to all of these complaints and the FOI request on 24 May 2021.

2.31 Laura contacted the AP at SCCE again on 3 February 2021 with a range of concerns regarding her mother and Chris's abuse of her. The AP consulted with a SAPC regarding next steps and was advised to check again with Doris's GP with respect to her capacity and care needs, and to speak with Doris and Laura. During the subsequent conversation with Laura, Laura told the AP she was concerned that future efforts by SCCE to engage Doris may alienate her from Laura, and so put her [Doris] at more risk. A further record the same day shows Laura told the AP she had visited Doris earlier in the week to pick up some sunflower seeds Doris had bought for her and Doris was mouthing something unknown when she got to the door. A drunken Chris appeared and started prodding Doris, saying 'I'll put seeds in you.' Doris had told Laura she had not wanted her [Laura] to see Chris, 'as he walks around with his hands down his trousers.' The SCCE AP called Doris the following day (12 February) and left a message requesting a call back. When none was received, the AP submitted an online form to the GP outlining their concerns. On 16 February, the GP contacted the AP via the surgery's online portal to advise that 'she has capacity'. SCCE records go on to show an email entitled 'FW: urgent [Chris] smashing things and picked up client and put her in her room, financial abuse, at home, East' that was sent from the AP to a Team Leader on the same day. This email appears to contradict the above record inasmuch as the AP advised the Team Leader they had received a call back from the GP confirming the GP had spoken to Doris and she had capacity and no cognitive impairment. There was no formal capacity assessment recorded for this intervention, and it appears the GP's statement was with respect to Doris's mental capacity to make decisions regarding taking her medication.

2.32 On 26 February 2021, the SCCE AP emailed the SAPC with an update. The AP reported they had spoken with Doris's daughter (record of which is stated in ASC notes from 11 February) who reiterated previously raised concerns about her mother and Chris and advised when the 'situation escalates and gets nasty' she [Laura] 'steps in' to challenge Chris's behaviour. As a consequence, Laura said, Chris 'gets super nice' and Doris 'forgets about all the nastiness before'. The email included that Laura had seen a Police charge sheet for

[10] Doppler test is used to detect blood flow. It shows whether a pulse is present and whether there is blood flow to a limb. It can diagnose or help to manage conditions such as peripheral arterial disease.

[11] Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters.

Chris in Doris's possession from which she learnt he had a history of living with women and when the relationship broke down, he became 'nasty' when he did not get what he wanted; with a previous woman, he threw urine over her and threatened to burn her house[12]. A further SCCE case consultation took place on 26 February between the SAPC and the AP the action from which was 'to call [Doris] anyway with the approach that we are following up concerns raised last year.'

2.33 On 3 March, Chris was seen by an outreach worker from Herring House[13] and was noted to be heavily under the influence of alcohol. He told the outreach worker that he 'had loads to tell' staff and would be in contact with them soon.

2.34 The AP contacted the SAPC on 5 March 2021 to advise they had spoken with Doris and 'she was quite happy living with Chris', and Doris 'was more focussed on [Chris's] wellbeing rather than her own' and 'he is not aggressive or threatening at all, that if he was, she would tell him to shove off and would not stand for any of that'. Doris felt she did not have care needs and is 'ok with handling her finances'. The record, however, goes on to state although Chris had been in a separate room when the conversation started, he entered the room whilst Doris was speaking with the AP and 'said something about signing a tenancy'. The AP recorded that the details of what Chris was saying were unclear and Doris 'did not elaborate'. At the end of this email, the AP stated that 'Doris then seemed to change tack in the conversation and started saying how she is having someone give her a quote for getting a shower installed downstairs.'

2.35 The following day, 6 March 2021, Doris's GP received a notification from an East of England Ambulance Service NHS Trust (EEAST) call handler stating that Doris's house guest [Chris] was intoxicated, and the call handler felt 'he was taking advantage of Doris's age and was forcibly remaining in the property against Doris's wishes.' The call handler stated, "the patient sounds helpless and unable to move the guest due to (her) age." No action was taken by the GP, aside from the notification being filed. The same concern was shared by EEAST with Norfolk Police who visited Doris but they could not locate Chris. EEAST attended again on 11 March when Chris's mother called them with concerns about his behaviour and alcohol consumption. A GP Mental Health Support Referral was made for Chris at this time.

2.36 Records from Herring House for 9 March show Chris met with an outreach worker and said he had a new tenancy and would need help arranging Housing Benefit because current arrangements would not cover his rent. The outreach worker discussed benefit change with Chris, and he said he needed to sort his methadone as it was 'messing him up'. The following day, 10 March, Herring House records show that Chris was discussed at a Housing First meeting, where a potential Criminal Behaviour Order (CBO) was flagged with regards to his anti-social behaviour on the local high street.

2.37 Also, on 10 March 2021 and following another case consultation between the AP and SAPC, it was decided that Doris's case should be closed. The same day Police records state Chris 'has convinced…[Doris] that the Covid vaccine is unlawful, and it will kill her. This has caused tensions between the family members of Doris'. The record notes Chris 'has a tenancy agreement with Doris which was witnessed by Chris's mum. Chris is planning on claiming housing benefit and then paying this to Doris.' It is not clear from the record how this information came to the Police, but the record closes with 'NFD' [no further details].

2.38 Probation records for 12 March show Chris attended Great Yarmouth Magistrates' Court for the offence of 'breach of community order'. This case was adjourned until 27 April to 'tie in

[12] Another record reported this assault was against an elderly man.
[13] See: https://www.herringhousetrust.org.uk/

with other matters.' The same day, EEAST was called by Doris for an ambulance as she had fallen and was unable to get up. Chris initially refused to help Doris, but then stated he 'was able to help her up as he usually does', so the call was cancelled by Doris.

2.39 Chris emailed Herring House on 17 March to request an appointment regarding accommodation questions and benefit advice. On 24 March, Chris attended the Herring House Centre and gave staff an assured tenancy agreement he had drawn up himself. Chris claimed he had done this so he could claim housing benefit at Doris' address. He was advised by staff at Herring House that he would need a Lodger's Agreement instead. Chris said he would do this himself as he had studied law in the past. Chris stated that Doris was having a small kitchen area built for her own use on the ground floor, as he occupied the first floor. Chris claimed that Doris's daughter did not like him and believed that he was 'wanting her mother's money'. Chris discussed being subject to Special Allocation Scheme (SAS)[14] with his GP and discussed his methadone prescription being arranged by an Ipswich GP. A further appointment was made with Chris for 31 March 2021 but he failed to attend.

2.40 On 23 March 2021, an ASSD East Approved Mental Health Professional recorded that a Housing First meeting had taken place and Chris had engaged with a Pathway Worker (recorded by Herring House as an outreach worker) from that service. Concerns were raised [by the Pathway Worker] regarding 'potential safeguarding' issues at Doris's home (the records do not contain specific detail of these concerns). The ASSD worker advised the Pathway Worker that 'recent safeguarding concerns in February 2021 had been explored with no further action as the outcome'. Further email contact was made between Herring House and an ASSD Mental Health East social worker on 26 March. In this email, the Herring House Trust worker again raised concerns about Chris's presence in Doris's home. Some 5 days later (1 April), the ASSD East Approved Mental Health Professional emailed Herring House to advise there were no actions following the 'recent safeguarding referral, but 'it is worrying that Chris would like to be migrated to universal credit in order to claim housing component'. There was discussion about whether lodgers can draw up their own tenancy agreement. It was felt this needed to be looked at more by safeguarding. There were no actions recorded for either agency as a result of this contact.

2.41 On 5 April 2021, NSFT (Mental Health Trust) patient records show the Police had asked the local Liaison and Diversion Team to see Chris whilst he was detained in Great Yarmouth Police station. The record states Chris declined to see anyone from this team and was given crisis support contact details as he left the station. There is no Police incident record related to Chris's appearance at the Police station at this time.

2.42 Chris attended A&E on 9 April with an infected burn on his leg. He self-discharged from hospital before his treatment was completed. Three days later Chris failed to attend a scheduled appointment with Change Grow Live[15] (CGL) on 12 April.

2.43 Herring House records for 14 April 2021, show concerns for Doris were raised by them to all professionals in a Housing First meeting. Staff noted when previous concerns were investigated Doris had responded that she felt safe in Chris's presence, but such investigations had been undertaken when Chris was with Doris. Staff were concerned this may mean Doris was not able to express herself freely, and it was decided when Chris was next at The Herring House Centre, staff would take the opportunity to call Doris and check when she was alone to ascertain if she was safe. This call was made by Herring House staff,

[14] Special Allocation Schemes were created to ensure that patients who have been removed from a practice patient list can continue to access healthcare services at an alternative, specific GP practice. NHS England has a responsibility to ensure that all patients can access good quality GP services and that patients are not refused healthcare following incidents that are reported to the Police. See https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/safety-and-quality/if-you-are-a-Dorisient-assigned-to-the-special-allocation-scheme/.

[15] See: https://www.changegrowlive.org/

but there was no answer from Doris. The following day, Herring House staff contacted the SCCE AP and expressed further concerns regarding 'Chris asking Doris for a tenancy agreement, generally taking advantage.' The AP advised care and support concerns regarding Doris had previously been addressed and the case closed. A discussion took place between the AP and the Practice Consultant Social Worker (PCSW, a senior social worker in the 'front door' service, SCCE) resulted in an action for the AP to call Doris to ascertain if there were any care and support needs, then to 'close as this is an ongoing issue that has been looked at twice now by the safeguarding team and closed as no care and support needs and no capacity issues.' The AP called Doris to discuss these matters the same day, 14 April 2021. Doris told the AP that she was happy and was managing to care for herself, although she was 'getting frustrated with everyone asking her about Chris.' The AP asked Doris about 'the tenancy agreement' and recorded that Doris said she 'is happy for Chris to live with her.' As a consequence of this telephone call, the AP recorded that Doris had 'no care and support needs… and no issues regarding capacity.' The subsequent decision of 'NFA' was passed to the referrer by the AP via telephone the following day. Herring House records for 15 April confirm 'Social Services are not going to do anything, as there was nothing wrong with her capacity, so Doris is just making 'unwise choices.'

2.44 Police attended Doris's home again on 18 April 2021, and an Adult Protection Investigation was raised for both Doris and Chris as 'medium' risk. No further action was taken by Police at this time.

2.45 Doris attended her GP surgery on 22 April with a painful shoulder, but there was no discussion regarding concerns previously raised with the GP about her safety in Chris's presence. On 27 April, Doris was late attending a GP appointment and was verbally aggressive towards the receptionist when told she was too late to be seen. As a consequence, Doris was sent a zero-tolerance letter by the GP warning her about her conduct.

2.46 On 27 April, Chris had a telephone appointment (due to Covid) with Change Grow Live CGL for an assessment of his needs. During this call, he became abusive towards staff members and towards Doris. Staff terminated the call and recorded that Chris should only be seen by 2 members of staff during subsequent appointments. The following day, staff at CGL called Chris but the call was 'answered by a female, assumed to be his mother' who advised the CGL worker that Chris was not at home. A further call to Chris was made the following day, 29 April, but there was no answer. The next day, 30 April, the service again called Chris, but Doris answered the phone. She advised she was not Chris's mother. She said that Chris had missed a court hearing the previous week, he had called the Police to inform them of his whereabouts, and they 'had picked him up that morning.' There is no record of this court hearing, or of Police 'picking up' Chris at this time. The CGL worker was to call Chris the following week.

2.47 Probation records show Chris appeared at Great Yarmouth Magistrates' Court the same day (30 April 2021) as per the call to Doris from CGL for a 'breach of Community Order and various Criminal offences.' The outcome of this appearance was:

i. Breach Outcome - revoked and resentenced to new stand-alone Suspended Sentence Order (SSO) for this and various other offences. Total sentence 10 weeks custody suspended for 12 months with no requirements.
ii. 11.10.18 - possession bladed article - 10wks Custody/12mths SSO No Requirement
iii. 23.07.18 - Sec 4A POA - No Separate Penalty
iv. 14.03.18 - Criminal Damage - No Separate Penalty.

2.48 On 5 May, Chris failed to attend a telephone appointment with CGL. A further appointment was made for 19 May. On 7 May, the Chief Executive of CGL received a letter from Chris

requesting his notes and information about the board of trustees. A CGL service director called him, but Chris did not recall having sent the letter. Chris's records for 7 May states 'all staff were made aware of potential safeguarding concerns regarding the female living with the client [Chris]. CGL did not have consent to talk to her.' On 11 May, CGL's locality manager and a team leader undertook a home visit to Chris. He was alone at Doris's home and told the manager and team leader that Doris had 'gone away for a few days.' Chris told them 'they had disagreements…but this was in the realms of normal relationships.' The following day, 12 May, CGL had a contact with 'health outreach special allocations GP service' who advised that Chris 'lived with his elderly mother' and he had been referred for support in April 2021. The health outreach worker advised Chris was prescribed 15mg Methadone daily, 30mg Diazepam daily, and Pregabalin and Sustanon every 3 weeks (to be self-administered). The health outreach worker reported Chris 'had a history of injecting Zomorph[16] and deliberate self-harm using injecting needles to damage his arms' but Chris had reported 'no illicit opiate use or injecting for some time.'

2.49 Police were called by Doris on 19 May, reporting that Chris would not leave her address. Police heard 'a lot of arguing in the background, between a female and male' and events were 'really kicking off.' On attendance, Police found a verbal argument occurring between Chris and friend of Doris's 'over some pictures on social media,' the content of these pictures was recorded. No further action was taken by Police.

2.50 Doris attended JPUH on 22 May with an abrasion to her knee, which she said had been caused after getting trapped in train door whilst on the way to friend's funeral on 16 May. EEAST records attached to this attendance state:

> *i. Doris lives with a lodger who initially moved in a few years back and stayed a couple of nights a week. Friend has then become full time tenant at the address and was very intoxicated at time of attendance. Doris states that friend stays awake all night and plays loud music during the evening. Doris also states that she feels scared when this is happening and has to lock their bedroom door to ensure that the friend does not wander in during the night. Doris states that the friend is drunk every day and they have to provide money each day in order to assist the friend with alcohol. Doris states that they feel scared of asking the friend to leave in case they kick off again which they have done previously, and Doris has had to call Police for assistance. Upon ambulance leaving friend at address was abusive to crew and banging on the side of the ambulance.*

As a consequence of Doris's disclosure, EEAST made a referral to Adult Social Care at JPUH containing the details given above.

2.51 The JPUH social work team called Doris on 24 May 2021 to discuss the referral and her leg injury. Doris said Chris was only supposed to be staying with her in the short term and he would become aggressive towards her when she refused to give him money for alcohol. Doris told the caller she would call the Police or her daughter if Chris became aggressive again. The social worker discussed a referral for Doris to the Assistive Technology Service for a fall alarm, and Doris had agreed to this. The record concludes that 'At no time during our conversation did I have cause to be concerned for Doris's ability to make informed decisions regarding these concerns.' The referral to the Assistive Technology Service was made the same day.

[16] Zomorph belongs to a group of medicines called opioid analgesics. The medication contains the active ingredient morphine sulphate in a special slow-release form which gives relief from severe pain.

2.52 On 26 May Doris called Police at 02:35hrs to report 'Chris was shouting and swearing at her' and Doris 'was very upset and did not want Chris at the address'. Police attended at 03:10hrs where they found Chris 'calm on arrival but a little obnoxious.' The record states:

> *'He was a tenant in her home and she was not happy with his behaviour, They are not in a relationship and never have been. He was shouting and swearing. Not a public order offence as they were both inside the same dwelling, no threats of violence. Doris advised to speak to a Solicitor if she wants to evict him. Chris was told to go to bed and improve his behaviour and show the female/house more respect. CAD and be closed, no Athena to record'.*

No further actions were recorded as a consequence of this visit.

2.53 On 27 May 2021, CGL called Chris to confirm his appointment with a Recovery Coordinator for 2 June, and a reminder call on 1 June when Chris said, 'he would try and attend.'

2.54 Doris called the SCCE AP on 1 June to request an assessment for Chris. The record of this call states:

> *'She [Doris] is wanting to get her lodger out of her home as she has had enough, she said her lodger, Chris, is 41 years old and an alcoholic, she said he is drinking around 1 bottle of gin per day and she does everything for him, he doesn't do anything around the house and sits up until 4am listening to music and she has had enough of it, I asked her if she has asked him to leave, she said several times, she said he is using a letter they put together as the excuse not to leave, she said she signed a document saying that when she dies, he can stay in the house for 3 years before he has to leave and she has talked to a solicitor about this who stated the letter means nothing but he still won't leave, she said she has also called the Police who have visited them both but as he isn't being abusive or threatening they just leave.*
>
> *Doris confirmed that he isn't being abusive but he just refuses to leave. Doris confirmed that despite her age, she is able to live independently and she manages all of her daily support needs and tasks without the need for support. I advised Doris that ASSD can't assist her with housing and tenancy disputes and told her to talk with Citizens Advice Bureau about her concerns, I gave her the telephone number for Great Yarmouth Citizens Advice Bureau 03444111444, she said she would call them to discuss her concerns and take their advice.'*

2.55 Also on 1 June 2021, Doris called Police at 21:13hrs as Chris was 'here again' and had called her a 'c***' and other 'horrible names.' Doris said they had argued over the curtains being drawn and she had locked herself in her bedroom. The record states Doris 'really wanted Chris to leave as he was making her life a misery.' The call-handler then advised Doris to call 999 if Chris came out of his room. At 22:15hrs, Police attended Doris's home and she was seen safe and well. No offences or complaints were recorded by Police.

2.56 Chris attended his nurse alcohol assessment with CGL on 2 June 2021. He presented as 'unkempt and in soiled clothing'. Chris told the nurse he did not want any information about him recording, and he was drinking 750ml of gin a day, starting when he woke up. Chris was 'hostile from the outset' and began using offensive language before walking out. A Client Recovery worker from the service tried to call Chris later the same day, but the call was answered by Doris. She stated that Chris was not at home, and she had had enough and 'wanted him out of her house'. Doris advised the worker that when Chris was 'paid the following week', Police had advised her to give him 2 weeks' notice to leave the property. Doris added that Chris had been verbally abusive to her and a 'friend', and her family wouldn't visit her whilst Chris was in the house. The Client

Recovery worker then asked Doris if she was afraid of Chris, to which she replied 'no, she just wanted him out.' Following a letter from CGL to Chris on 7 June, Chris left a voicemail with CGL on 12 June with 'abusive content'. On 15 June, Chris called CGL regarding his GP prescriptions. During this call, Chris became abusive and stated he no longer wanted support from the service.

2.57 On 16 June, a CGL worker called Doris to 'see how she was'. Chris answered and was 'rude' to the worker who ended the call as a result. Two days later, on 18 June, a CGL worker called again and spoke with Doris who said she had written a letter to Chris asking that he leave her address by 25 June. The worker asked Doris if she was afraid, to which she responded, 'she was not' and she would contact Police if Chris had not left by 25 June. Also on 18 June, Doris attended a new GP surgery and was seen by a clinical practitioner. Doris disclosed she was accommodating 'a 41-year-old homeless man temporarily who is an alcoholic. He lives upstairs. He gets drunk, has broken chairs and he falls. He has once lifted her and threw her on a chair. He swears all the time and talks to the television as a human being. She has told him to leave within 2 weeks.' As a result of this disclosure, the GP discussed the case with the surgery safeguarding lead and arranged a follow-up call with Doris.

2.58 Chris contacted Cambridge City Council Customer Service Centre on 22 June asking for support into accommodation as he was being victimised in Norfolk by local residents. Following checks with Doris and Norfolk Police, Chris's application for accommodation was refused and his case was closed on 9 September.

2.59 Laura called SCCE on 24 June to report that Chris had broken a lock on Doris's bedroom door. The record for this call states:

- *Mother [Doris] is desperate for Chris to leave the house. Doris thinks the Police may be coming on Friday to throw him out.*
- *Chris is living in Doris's house. Caller stated he took advantage of Doris when she was grieving after the loss of her sons and moved into her property. They became initially became friends but that relationship has broken down.*
- *Chris had/has MH problems and alcohol dependency. He's been banned from XX town centre because of his behaviour.*
- *Various things in house are getting broken by Chris.*
- *Daughter thinks that Chris is displaying controlling, coercive, behaviour.*
- *Mother has been frightened for her life in the past, due to Chris's behaviour, and has called the Police.*
- *Mother [Doris] is very willing to believe what other people tell her, caller states, so vulnerable.*

Does the person have any care and support needs (appearance of need)?
- *Dr phoned Doris and he found her memory to be fine. However, she doesn't retain an emotional memory of things that have happened between Chris and herself. She doesn't appear able to recall having conversations with daughter about it.*
- *Doris has hurt knee badly so is struggling to get up and move around - she feels she needs support (caller states).*
- *Caller mentions inherent jurisdiction.*

Has actual harm (physical, emotional, financial, etc.) to the person occurred?
- *Financial - Chris has been taking money from Doris over a period of time (buying him alcohol etc.).*
- *Emotional - Chris talked her into signing a piece of paper saying he could stay, making her feel scared.*

- *Chris tied string round her finger and she got scared and phoned the Police. He picked her up once, physically, to stop her leaving the house because she was scared. He put her back in her room.*

Has Police/GP/medical input been required?
- *Yes, Police involved frequently (Doris has called the Police on occasion, and possibly friends of Doris).*

Does the person have capacity in relation to the incident?
- *In some respects, she has good recall but in others she doesn't. Caller is finding it difficult to explain the things her mother is experiencing currently.*

Is the person aware the referral has been made?
- *Yes.*

2.60 The following day, 25 June 2021, the SCCE AP called Laura back. Laura reiterated the concerns raised in the previous day's telephone call, and further advised that Chris had told Doris she should take back control of her finances from Laura's son, Jack, who had been looking after these for his grandmother. Laura was concerned Doris was paying for Chris's daily gin intake, and Doris had told her Police were due to visit that day to remove Chris from her house. Later the same day Laura called SCCE back to advise that Police were not coming to visit Doris, but Chris's mother had visited him at Doris's home to pack his clothes ahead of him leaving at some point in the day. The SCCE AP advised Laura that should Chris not move out, then Police should be called. Laura agreed to call the AP back to advise if/when Chris had moved out. A CGL worker tried to call Doris on this date, but Chris answered the phone and said Doris had gone out for a meal with friends.

2.61 Police did attend Doris's home on 25 June as Doris wanted Chris removed from her home. Chris produced a copy of a 'Tenant's Agreement' and on reading this, attending officers concluded it was 'more of a civil matter.' Police advised Doris she could verbally inform Chris to leave, with the Police as witnesses, but this was not done at the time as officers were unaware of the minimum notice required. Police uploaded a copy of the 'Tenant's Agreement' to their Athena database, and spoke with Laura advising her to contact Great Yarmouth Borough Council to ascertain the minimum notice required. An attached entry log for 28 June 2021, states Laura called Police back to advise the notice period was 1 week, and she needed Police help to serve this notice on Chris. Laura followed this call with an email to Police but received no response.

2.62 On 28 June 2021 Laura called SCCE providing an update on events 3 days prior. The same day, the SCCE AP contacted the Assistive Technology Service to follow up on Doris's referral as there were 'possible safeguarding issues.' Assistive Technology confirmed they would undertake a home visit with Doris the next week. Also, on 28 June the clinical practitioner at the GP surgery rang Doris back as a result of the disclosure she made on 18 June. Doris stated that a 'homeless individual has been squatting in her home has not left…Police came round last week...he does not hurt her again…she has her doors locked.' The practitioner discussed the case with the GP with a plan to refer to the Social Prescriber Service 'for social issues and frailty.' The same day a CGL worker called Doris, who advised she had called Police as Chris was refusing to leave, but Police had told her that her first notice letter to Chris was not valid as it had not been witnessed, but they would be 'witness to him leaving' and remove him from the property if he did not leave. Doris told the CGL worker she was unsure if this would happen 'that particular week or the following week.'

2.63 The following day, 29 June 2021, CGL held a 'multi-disciplinary discussion' following Chris's attendance at his nurse alcohol assessment. At this meeting, Chris was challenged regarding his 'unacceptable behaviour towards staff.' Chris became abusive, stated he did not want a service and walked out. He was discharged the same day, with a note made explaining 'Police were aware of Doris's situation.'

2.64 On 30 June, the Assistive Technology Team called Doris and Laura to undertake an assessment relating to Doris's earlier fall and A&E attendance. They were advised Chris had moved out, but the 'downside' to this was Doris was now alone. A community alarm was to be installed at Doris's home.

2.65 A Community Health Social Prescriber (CHSP) from Doris's GP surgery made a safeguarding contact with the SCCE AP on 2 July based on Doris's disclosure on 18 June. The AP called the Social Prescriber back the same day, and on 6 July when they left a voicemail. Medical records from JPUH for 2 July also show Chris was discharged from a Clinic as JPUH had been unable to contact him. GP records show that a Social Prescribing Health Coach received an email from Police confirming officers had attended on 25 June 2021 'following a call from Doris requesting Chris be removed. PC stated a tenancy agreement had previously been signed by both Doris and Chris for 3 years or until the tenants decide to rescind.' The record includes 'PC advised the Police had no powers to remove Chris due to the tenancy agreement in place and Doris would need to seek legal advice as to how she can get Chris removed. Advice for Doris to call Police if Chris becomes threatening. Safeguarding Adult referral made.'

2.66 On 6 July 2021, the SCCE AP discussed the referral from the Social Prescriber with their Team Manager who advised there was no role for safeguarding and Assistive Technology would be making a home visit to Doris 'in the next few days.' The AP intended to call Laura to see if Chris had left Doris's home, and prior records were reviewed to confirm there was no role for adult safeguarding. As a result, the Social Prescriber contact was closed the same day.

2.67 The next day, 7 July 2021, Chris was sent an appointment letter for the Endocrine Clinic and a blood test. He was seen at this clinic on 16 July where he requested further detox treatment. Records show Chris 'continues to deny Covid measures,' and 'Concerns' by staff that an inpatient admission would be 'challenging' due to his non-compliance with Covid measures.

2.68 Also in July the SCCE AP received a telephone call from the Social Prescriber to report they had spoken with Laura and Chris was still at Doris's home and 'Doris has not asked that he move.' The AP advised the Social Prescriber that Assistive Technology had installed an alarm to 'call for help if she needs support i.e., has a fall' and Doris's daughter was in contact with her mother. Laura, Doris's daughter, disputed this record when she met the Chair and Author in March 2024. Laura stated that the Social Prescriber, who she could name, had raised concerns about Doris and that Doris had told the Social Prescriber 3 times that she wanted Chris to leave her home. The Social Prescriber had contacted Laura as they had been advised by ASC that Doris's case was to be closed, and the Social Prescriber wanted to let Laura know that 'nothing could be done'.

2.69 Again, in July, JPUH received a telephone complaint from Chris which was recorded as 'muddled', 'verbally abusive', and he made threats against the Deputy Director of Nursing at JPUH. This call was terminated by the JPUH practitioner, and alerts were sent to the main reception, A&E, and security at JPUH as a consequence of Chris's threats. Norfolk Police were called by hospital staff at this time.

2.70 Also in July the Police were called to a 'dispute' at Doris's home whereby:

> *Doris had gone to a neighbours address and Chris remained at the home address. Doris confirmed there had been a dispute regarding pasta however Chris was intoxicated, had been drinking heavily, and started shouting at Doris so she left. Doris originally let Chris into the address as she felt sorry for him as he was homeless however in recent weeks is unsure whether she wishes for him to remain there. Doris states that Chris has taken over the majority house and his alcoholism has become difficult to live with. It is believed that Doris left her house due to being in fear of violence however Doris did not confirm this and only wished for Chris to be removed for the night due to how drunk he had got and his poor behaviour.*

Four officers were in attendance. Chris's attitude to officers was combative and he waved a paper at them insisting he had a tenancy agreement. Police records explain Chris was removed from the address and threatened with a breach of the peace, but 'due to uncertainty of offence occurring' and Doris unable to confirm any offence had taken place, he 'would be welcome to return in the morning.' On departing, the Police recorded that Doris had locked the front door to her home but had to place 'a chair on top of a cool box' to wedge her back door shut, as she was not able to find a key. Doris was advised to call Police if Chris returned. This is the last Police record relating to contact with Doris. Her daughter reported her missing the following morning, and some days later, Chris was arrested and charged with Doris's murder. Doris's body was unable to be recovered; the remains of a fire in her garden provided evidence of the steps Chris had taken to conceal his crime.

2.71 Chris was convicted of murder and arson. In May 2023, he was sentenced to life imprisonment with a minimum tariff of 35 years.

3. Key Issues Arising from the Review:

3.1 One of the most concerning issues arising from the review is agencies' failure to act on the information available which highlighted the risk the perpetrator posed to Doris. His past history held by the Police and Probation, his threatening and abusive behaviour towards GP, hospital, drug and alcohol charity staff, overheard comments in phone calls by Adult Social Care, plus reports of his abusive behaviour reported to Adult Social Care by Doris's daughter were not taken sufficiently seriously or shared and coordinated.

3.2 Concerns for Doris's safety and the abusive behaviours Chris was exhibiting were regularly reported by Laura her daughter. She frequently tried to highlight the risk she instinctively felt her mother was facing and she reported and named his coercive and controlling behaviour and financial abuse as he used Doris's money to support his excessive drink and drug habits. Despite her many contacts Laura's information was not taken seriously and given the credence it deserved. Laura knew her mother better than any professional and she is a safeguarding professional, yet this was not considered by practitioners making assessments.

3.3 Agencies failed to recognise that as a member of the same household the abusive behaviours used by Chris came under the definition of domestic abuse and should have been risk assessed as such. Although initially a sexual relationship was suggested by reports by Doris to her granddaughter and daughter, this was soon disregarded and domestic abuse was not recognised as agencies did not consider Doris and Chris to be in a relationship.

3.4 Over the many months Chris lived in Doris's home he gradually took over the accommodation and at one stage Doris planned to make sure he could live in the house if anything happened to her. Just before she was killed she had removed this from her Will. Doris offered Chris accommodation as he was homeless, but it was meant to be for a short time only. However, she was unable to remove him from her home and agencies did not adequately respond when she wanted assistance. Agencies failed to see Chris's controlling behaviour and intransigence when it came to moving out as 'cuckooing', even though a 'cuckooing' policy exists.

3.5 Doris's daughter was concerned about her mother's mental capacity as she had observed a change in her personality and memory following a fall some years ago. However, no formal mental capacity assessment took place. Doris was not seen in person by a social worker or her GP for a full assessment. The ramifications of the Covid pandemic and changes in face to face appointments, may have been a consideration, but the risk to Doris should have made a home visit or in-person assessment essential.

3.6 In addition to Doris's daughter Laura's contact with services, other services raised safeguarding concerns about Chris's presence in Doris's home. However, Adult Social Care assessments following these contacts concentrated on her 'care and support' needs, not the need for safeguarding to protect her from Chris. No background information was gathered internally or from other agencies such as the Police to gain a fuller picture to inform risk assessment and the potential to move to a full Care Act Section 42 safeguarding enquiry.

4. Conclusions:

4.1 There is no doubt that Doris was a very caring and trusting woman who took pity on a fellow human being because he was homeless, and this led to her offering him a roof over his head. This took place shortly after she experienced a second bereavement with the loss of her second son who was Doris's carer. Whether this significant loss played a part in Doris's decision to be a 'Good Samaritan' to Chris who was a similar age to her son we do not know. Similarly, we do not know whether Doris's character changes described by her family which included being less inhibited and more extrovert, caused her to become less guarded and conscious of her personal safety. In one conversation with a practitioner Doris said the arrangement with Chris was meant to be for a day or two, not long term. She commented that she 'had learnt her lesson and would not do this again', and she 'enjoyed living on her own'. However, removing Chris from her home proved far more difficult than she or her family could have envisaged.

4.2 The review has been unable to establish whether Doris lacked capacity to make decisions as no effective Mental Capacity Act assessment took place, and she was not seen in person by a practitioner with the training to undertake such an assessment. Nevertheless, from records we can see that Doris appears to have changed her mind periodically regarding whether she wished Chris to continue living in her home. However, given that she was not seen in person, it is not possible to establish whether she was always able to speak freely. There is evidence of Chris's entrance into the room during a phone call appearing to have caused Doris to change the subject.

4.3 Family members raised their concerns on at least 5 occasions to ASC and 3 times to Police, but insufficient weight was given to the clear descriptions given of Chris's behaviour which demonstrated abuse, and in some cases acts such as assault, financial abuse, and coercion which are crimes. It is worthy of note that Doris's daughter is a safeguarding professional and yet she was unable to achieve the investigation she fervently believed was required.

4.4 Assessments of Doris focussed on her 'care and support' needs, not the risk Chris posed to her, and yet whether a person is 'experiencing, or is at risk of, abuse or neglect' should also

be assessed under the Care Act. Even when the first concerns raised suggested there was an intimate relationship between Doris and Chris, domestic abuse was not considered. Chris's previous criminal history which contained relevant background of allegations of crimes against women and the abuse of a vulnerable man he moved in with was not examined and considered. In addition, even the trail of referrals raising concerns for Doris were not considered in their entirety. Thus, a pattern of behaviour by Chris was not identified. Even acknowledging the effect of hindsight bias, there were continual references to very worrying behaviours which clearly flagged an escalating risk to Doris. Referrals appear to have been viewed in isolation.

4.5 Whilst Covid restrictions and resources played some part in the response, in particular of Adult Social Care, such was the information in the safeguarding concerns a home visit to Doris without Chris present should have taken place.

4.6 Chris's manipulative behaviour in drawing up a tenancy agreement which had no legal basis to coerce Doris into believing she could not remove him for 3 years, is just one example of his coercive and controlling behaviour described in this review. Whereas 'cuckooing' is normally associated with drug dealers taking over a vulnerable person's home, in this case Chris appears to have manipulated his way in to obtain a roof over his head in the long term and to financially abuse Doris. Chris tried consistently to gain the proprietary rights to Doris's home, and her eventual rejection of his behaviours and the likelihood that Chris became aware that Doris had changed her Will led directly to her death.

4.7 There was a fundamental failure to recognise the risk Chris posed to Doris. Doris was a petite 83-year-old woman who had mobility and balance difficulties which required her to use a mobility walking frame, and although Doris may have held her own verbally with Chris on occasions, physically he towered above her in height and build. When he was drunk, Doris would have been powerless, and there is reference to her locking herself in her room on such occasions in what was her own home. Chris was known to be aggressive to the extent the Police and practitioners saw him in pairs. That in itself should have raised the risk to 'high'.

4.8 Doris and her family needed multi-agency coordinated action to achieve the removal of Chris, to protect Doris, and to secure her home to prevent his return. Despite the repeated number of callouts and safeguarding concerns no one took stock and looked at options available such as a Non-Molestation Order or Exclusion Order to try and remove Chris, or for improving the security of Doris's property. Tragically, no joined up action took place.

4.9 In addition, gaps in agency / practitioner awareness of adult safeguarding provision, terminology, and processes may have led to assumptions being made about Doris's care during the period under review.

4.10 Doris's daughter took issue with a number of issues raised in the review. An abridged statement by Laura is attached at Appendix 1. Her full statement can be found in the DHR Overview Report.

5. Lessons to be Learnt:

Listening to Families

5.1 Doris's daughter and granddaughter did all they could to raise their concerns about Chris being in Doris's home. They rightly feared he posed a risk to Doris after realising the type of behaviour he was exhibiting and from things Doris told them. Laura explicitly raised the issue twice of Chris exerting coercive control with Adult Social Care (3 February 2021 and 24 June 2021). However, the gravity of their concerns was not considered despite the Police and Herring Housing also raising concerns which corroborated the issues raised by the family.

Laura also alerted Adult Social Care to Chris offending history, but this vital information was ignored.

5.2 Winter and Cree (2015) in assessing social work practice suggest 'the views of families or para-professionals were not often drawn upon or were seen as less credible in contributing to assessments of risk, even though they may see the individuals concerned on a daily basis and in their homes, and therefore may be far more attuned and alert to changes in condition and presentation' (p22). This appears to reflect Laura's experience as evidenced by the number of contacts she made with services, especially with Adult Social Care.

5.3 Family members know the person for whom concerns are raised better than anyone. Normally they will have known their loved one the longest, and in Doris's case her family lived close by not miles away where they might not have a full picture. There should not be a hierarchy of credibility where information from agency's practitioners takes precedence over that provided by families. Working with families is also noted to be good practice.

Recognition of Coercive Control and Links to Cuckooing

5.4 It was initially unclear whether Doris and Chris were in an intimate relationship as told by Doris to her family and which they reported to the Police and Adult Social Care. There is a sense of some scepticism, if not agism, that a woman in her 80's would be in a relationship with a man in his 40's which affected the acceptance of the initial referrals as constituting domestic abuse. Doris and Chris did, however, deny an intimate relationship during one of the Police visits. This meant ongoing callouts and referrals were not framed as domestic abuse which reduced the recognition of coercive control. We also have a difference in definition whereby for the Police domestic abuse is defined as abuse by an intimate or former partner, or a family member, whereas the criterion for Domestic Homicide Reviews includes a homicide by a member of the same household. Chris was a member of the same household in the months he lived in Doris's home. It is arguable that a member of the same household would have equal access to a member of that household as they would to a partner or family member, as was the case for Doris who had Chris living with her who was unemployed and in her home a significant amount of time.

5.5 Whilst a domestic abuse definition may not apply in this case, behaviours constituting coercive and controlling behaviours do. Although the offence of controlling and coercive behaviour is an offence within domestic abuse relationships, it is clear that Chris was both manipulative and controlling of Doris. When interviewed for this review Chris appeared verbose, intelligent, and assertive; he was adept at controlling the direction of the conversation. Doris may have invited him into her home, but she told a practitioner in September 2020 this was just for the "odd few nights" and she "would not do it again". It is evidence of his control that he remained so many months in her home, even convincing her of the validity of his self-written tenancy agreement.

5.6 Although traditionally connected with 'county lines' and drug dealers taking over the homes of vulnerable people, cuckooing[17] techniques were used by Chris. He took over parts of Doris's home, for example one of the downstair receptions rooms, which Police body-cam footage showed had a bolt fitted to the top of the door which would be out of reach to Doris. He obtained money from Doris to fund alcohol, interrupted her phone calls to prevent her speaking freely, and he isolated her from her family. He self-harmed possibly to intimidate or make Doris feel guilt and sympathy so that he could stay; he also used alcohol and drugs in her home. These behaviours are just some we know about, and they are among examples listed in a

[17] Cuckooing is an inherently exploitative and predatory practice. Existing evidence indicates that victims are typically vulnerable and in some instances, socially excluded. Victims include drug and alcohol users, sex workers, the elderly, single parents, and those with learning difficulties, disabilities and/or mental health issues. https://www.Understanding and preventing 'cuckooing' victimisation | College of Policing.

Home Office (2023) publication on the criminal exploitation of children and vulnerable adults as used by those who 'cuckoo' vulnerable adults.

5.7 Doris's situation provides an important lesson for agencies and practitioners to recognise that cuckooing and coercive and controlling behaviour can take place outside 'county lines' type cases. Had there been closer scrutiny and multi-agency discussion the whole picture and Chris's behaviour could have been identified. This is reinforced by Home Office Guidance (2023) for ways of working in such cases which includes:

- Use reachable moments to connect with the vulnerable person and actively seek inputs from different professional perspectives to build a picture of the whole story.
- Effective collaboration and information sharing between agencies is essential to protecting victims and disrupting offenders. It is therefore important to provide as much information as possible as part of the safeguarding referral process. This will allow any assessment to consider all the available evidence to address harm.
- Proactive sharing of other contextual information, such as assessments that have been undertaken, referrals for support or other measures that are in place for a vulnerable person will help partners act more effectively.
- Understand the multi-agency safeguarding arrangements and groups you can report information into locally which can enable this collaboration, including but not limited to: child protection strategy meetings, Multi-Agency Safeguarding Hubs, Multi-Agency Child Exploitation panels (or equivalent), Community Safety Partnerships, Combating Drugs Partnerships, Multi-Agency Public Protection Arrangements.
- Parents and families should also be considered safeguarding partners. Listen to their concerns seriously and discuss solutions with them as they could help practitioners recognise what will work best.

5.8 The Home Office guidance (2023) suggests "in cases of cuckooing, the police, local authorities, and housing associations can take action to evict the offenders and support the victim to regain control of their property through the application of civil orders such as Closure Orders and Community Protection Notices which can be used to close down premises that are being used for criminal activities. You should consider how the use of any order will impact on the victim's safety" (p14). However, Doris's home was privately owned therefore a Closure Order would not have been applicable, but other injunctions could have been considered. Her wish to have Chris removed from her home was constantly seen as a civil matter.

Assessment of Risk Informed by all Agency Information

5.9 Although the Police recognised Chris posed a risk to the extent they visited in pairs, the risk to Doris herself appears to have been significantly under appreciated. His previous offending history and the potential relevance of some of those offences to Doris were not effectively factored into risk assessments. Chris's aggression had led to him being banned from his GP surgery in November 2018 so that he had to collect his prescriptions elsewhere, and the hospital reported having to call the Police during one of his attendances (in August 2020) as their own security felt unable to manage him. His aggression was well known but minimised or ignored when considering Doris.

5.10 There was a failure to identify the accumulating risk to Doris, despite there being 11 key contacts, including 7 safeguarding concerns, and the fact she was not assessed in person meant her added vulnerabilities due to limitations to her mobility were not assessed, nor in respect of the risk Chris posed. Doris was always assessed for her 'care and support needs', practitioners and their managers appeared to be fixated on this aspect of her life, and when Doris said she did not have these needs the case was closed. The parts of the Care Act requiring assessment of whether Doris was 'experiencing, or is at risk of, abuse or neglect', were ignored. Had the case been treated as domestic abuse, repeat incidents and

callouts would/should have triggered Doris as a repeat victim and possible referral to the Multi-Agency Risk Assessment Conference (MARAC).

5.11 Effective risk assessment relies on information from a number of sources to gather an holistic picture of what is taking place, and it needs regular review and updating when situations change or further incidents happen. Lack of information sharing and risk assessment has been identified in research (Warburton-Wynn 2021[18]) as one of the most common issues in Safeguarding Adult Reviews. Undoubtedly, when Covid restrictions were in place this disrupted some agencies' ability to conduct home visits, but this heightens the need to ensure information is obtained from a wide variety of sources, some of whom, like the Police and Ambulance Service, continued to visit homes when called upon.

5.12 Chris did not comply with his Community Orders, and he showed no commitment to engaging with Probation. This suggests at best a disregard for the law, at worst contempt. Police body-cam footage shows Chris's style of conversation with officers as very assertive and combative. His attitude and disregard for law enforcement is another behaviour which required consideration in risk assessments.

5.13 Risk posed by Chris to Doris was not considered. It is essential that agencies assess risk not only *to* the vulnerable person but consider all background and the risk *from* the person causing the concerns. Greater focus on Chris would, or should, have rung alarm bells.

5.14 The fact that risk to Doris rather than an assessment of her 'care and support needs' was not correctly assessed meant there was no progression to a Section 42 enquiry which would, and should, have resulted in multi-agency information sharing to identify and mitigate risk. What appears to be a reluctance to undertake Section 42 enquiries needs to change.

5.15 The function of the MASH in such cases has been alluded to and the Panel has discussed this issue. A review of the MASH is underway at the time of writing.

Professional Curiosity

5.16 Sadly, a lack of professional curiosity is a recuring theme in DHRs (Home Office 2021) and it continues to be a lesson to be learnt in this review. The absence of professional curiosity was highlighted within the Adult Social Care IMR as a lesson to be learnt. This shortcoming in practice meant significant pieces of information were overlooked and opportunities to intervene were missed. The impact of the trauma of losing her two sons was not considered in relation to Doris's decision-making (for example did Chris remind her of her son?). At no point did anyone explore why Doris had let Chris come to live with her or pick up that she might be lonely, although she did say she enjoyed being on her own and she had the members of church community. She also had regular physical contact with her close family prior to Chris's arrival, and contact with Laura especially, was maintained on a daily basis over the telephone after Chris had 'cuckooed' Doris.

5.17 There were many occasions when careful questions could have probed to illicit examples of Chris's abusive behaviours for evidence in assessments, and behaviour such as Chris taking the phone from Doris and being abusive to the caller, or Doris making out the call was about fitting a shower when Chris came into the room did not engender further questioning and the case was consistently closed. It was apparent from one telephone conversation with Doris that Chris was in the room when a practitioner was speaking to her, but this was not considered and ways to speak to her safely were not considered by ASC staff.

[18] A Review into Domestic Homicide and Safeguarding Adults Reviews Relating to Victims with Additional Vulnerabilities - Shaping Our Lives

5.18 Other services also identified missed opportunities to show greater professional curiosity. Change Grow Life found their staff should show greater curiosity in determining risk to others when engaged in telephone assessments. Hospital staff should also ask all patients (alone) if they feel safe at home and document this on the patient's record.

Mental Capacity and the Impact of Coercive Control on Capacity

5.19 Questions about Doris's mental capacity was a constant throughout the consideration of referrals. However, the Adult Social Care IMR judged this emphasis came at the expense of exploring the nuance of Doris's situation i.e. taking account of forms of abuse such as domestic abuse, exploitation, or coercion and control and the impact of these on her decision-making.

5.20 The GP was consulted several times about whether Doris had capacity, but the consultations conflated capacity and cognitive impairment. Capacity is decision-specific, and the GP was not asked to make a formal capacity assessment with regard to Doris's ability to make a decision about Chris living in her house. The lack of specific requirement in the request and the fact that Doris did not appear confused in a telephone conversation affected the GP response. The lesson drawn was that practitioners did not seem to understand how to frame the question to the GP to help establish whether Doris had capacity with regard to Chris or whether further assessment was required. While Doris presented on the telephone as having decisional capacity, her executive capacity was unclear as she frequently said one thing (e.g., that she wanted Chris to leave) but in another call would say she was happy for him to stay.

5.21 There was no recognition that coercion and control can affect capacity and that a lack of a diagnosis of cognitive impairment would not preclude taking some action if there were concerns. No consideration was given to the impact of gaslighting, or Stockholm Syndrome[19] and the part this can play as a result of coercion and control over time. There are key symptoms of Stockholm Syndrome[20] which may apply to Doris which could have affected her capacity to act in her own interests, namely:

- Positive feelings towards the captor.
- Support of the captor's behaviour and the reasoning behind it.
- The victim begins to perceive their captor's humanity and believes they share the same goals and values.
- They make little to no effort to escape.
- A belief in the goodness of the captor.
- Feelings of pity towards the captor, even believing that their captors are victims themselves. They may have feelings of wanting to 'save' their abuser.
- Aside from having an attachment with their captor, victims may also develop different feelings towards outsiders. For instance, they may: Be unwilling to engage in any behaviours that could assist in their release. Have negative feelings towards their friends or family who may try to rescue them.
- Develop negative feelings towards the police, authority figures, or anyone who might be trying to help them get away from their captor.
- Refuse to cooperate against their captor, such as during the subsequent investigation or during legal trials.
- Believe that the police and other authorities do not have their best interests at heart.

[19] Whilst not a formal mental health diagnosis Stockholm Syndromes is the name given to cognitive changes identified whereby hostages increasingly identify with their captor and change their behaviour accordingly.
[20] Stockholm Syndrome in Relationships: Impact On Mental Health (simplypsychology.org)

- There are several reasons why someone may find some connection with a captor. It could be that spending an extended amount of time with any person can result in some positive feelings being established, without this being Stockholm Syndrome.

5.22 Research for 'Safe Care at Home' (2023[21]) highlighted the need for improvement in the interaction between the Mental Capacity Act 2005 and the Care Act 2014. The research identified that "stakeholders reflected that in some cases, section 42 enquiries under the Care Act 2014 may not be investigated fully if there is any question about the victim's mental capacity" (p47 paragraph 108). The research also identified variations in practitioner's understanding of mental capacity. Similar issues have been identified in Doris's case. The use and application of (including assessment) mental capacity continues to challenge many agencies across the Norfolk partnership. While there are pockets of good practice, in this case we have identified significant gaps in understanding, application, and confidence in using the Mental Capacity Act. This inconsistent position means that, in this case, Doris's rights were not being correctly protected, and decisions were taken which were not defendable.

5.23 A previous DHR in the county has identified the need to examine the operation of Section 42 of the Care Act 2014 and the criteria enabling services to make enquiries, and its impact on being able to assess and safeguard a person who has mental capacity, but who may be experiencing coercive control which affects their ability to consent to an assessment and freely express their views. As a consequence, a recommendation was made in that DHR for the Department of Health & Social Care, and the Home Office, in collaboration with the Domestic Abuse Commissioner for England & Wales, to commission urgent research to examine the operation of Section 42 of the Care Act 2014 vis a vis mental capacity and coercive control. Therefore, no similar recommendation will be made, but in recognition of the time it takes to achieve national change a local recommendation has been made regarding mental capacity training.

5.24 Assessing mental capacity is complex. It requires effective training for assessors, and sufficient training for those requesting an assessment to enable them to clearly communicate the capacity to be assessed. Most importantly, the training needs to include recognition of the impact of coercive control on an individual's ability and freedom to make safe decisions.

Recording and Assessments

5.25 Shortcomings in information available due to poor recording is a further issue consistently found in DHRs. It is also a finding in an analysis of SARs.[22] Records lacking in detail or examples explaining reasons for concerns affect decision making at the time and later if and when further referrals are received. An adequate and easily located chronology of key events or incidents is also crucial to assist practitioners in completing safe and effective assessments. Such a chronology should be available immediately after the main personal details screen of the person concerned. This would enable repeat referrals and concerns to be immediately visible, any patterns of behaviour to be identified, and risk to be assessed effectively.

5.26 A seemingly simple error in recording can have significant ramifications. For example, Doris was known to most people by her middle name but according to Laura, this changed when Chris moved into her home. This resulted in a duplicate record being created for Doris by a practitioner who then failed to record the presence of a duplicate record. Thus, some of the historic recording may not have been available to practitioners reviewing the record. To date it

[21] Safe Care at Home, June 2023, HM Government. Safe_Care_at_Home_Review_.pdf (publishing.service.gov.uk)
[22] (Local Government Association, 2024) 'practitioner briefing' See: https://www.local.gov.uk/our-support/partners-care-and-health/safeguarding-resources/analysis-safeguarding-adult-reviews-4

has not been possible for LAS colleagues to identify what information was recorded on the original record before the duplicate was created.

5.27 Where information is not clear in referrals or sufficiently detailed this should be followed up and clearly recorded. For example, the referral from the Pathway worker raising concerns for Doris recorded in Adult Social Care notes stated 'potential safeguarding issues'. What those issues were is not recorded or followed up to inform the Care Act assessment. Recording needs to be explicit and unambiguous to inform assessments especially where safeguarding a person is concerned.

5.28 Chris's previous offending history was not recorded on the safeguarding referral from the Police to Adult Social Care, nor did Social Care practitioners check their own records for Chris's background which would have revealed this crucial information.

Multi Agency Coordinated Response

5.29 The value of multi-agency coordination cannot and should not be underestimated. It is at the core of managing risk in domestic abuse cases whether that be intimate partner abuse, familial abuse, or as in the case, where the perpetrator is living in the same household as the victim. The day to day sharing of accommodation means the victim has a lengthy period of time exposed to danger by the very nature of their close proximity to the perpetrator, therefore it is arguable that even though not considered a domestic abuse case by agencies, similar best practice systems to protect the victim are required.

5.30 As has already been discussed, multi-agency working would have brought together all pieces of the information jigsaw to build a fuller picture. This was particularly the case to manage Chris's behaviour and the risk he posed to Doris, both in terms of his criminality, his mental ill-health, substance misuse, and housing needs.

5.31 Pre-sentence reports were not completed to inform the court disposal of Chris's case for breaching Community Orders, nor were checks made with the Police by Probation or Adult Social Care. Chris himself in interview for the review said he expected a custodial sentence and wished this had happened.

5.32 Anyone such as Chris with a variety of problems will undoubtedly have a corresponding variety of contacts with services. He was a difficult individual to engage with as can be seen in this review, thus a coordinated consistent response by services was essential. Mechanisms for coordinating complex cases involving risk exist but they were not put into action and information was not fully shared.

5.33 A common understanding of terminology, provision, and processes is key to an effective multi-agency response. Some confusion has been articulated by the DHR / SAR panel with respect to adult safeguarding in Norfolk. Similar confusion, regarding local roles and terminology was also raised in the GYBC IMR submitted to this review.

Training

5.34 Post Covid, there has been a growth in online training, and a significant amount of training also appears to be within agencies or for specific practitioner groups. Whilst recognising this is in response to Covid restrictions, online training now seems embedded as normal practice. Staff time and resource pressures are also a factor. However, the shift from multi-agency in person training reduces the opportunities for practitioners to meet, network, and to gain an understanding of other's roles in related services with whom they need to communicate in a safeguarding situation.

5.35 Analysis of Domestic Homicide Review recommendations consistently find a lack of inter-agency working as a common theme. Research by Jones et al (2022) highlighted the benefits of training to both specific professional groups in addition to interagency training as research suggests professionals develop confidence to speak with victims, and to take appropriate action following interagency training. Understanding other's roles and building professional relationships may also help to break down barriers which contribute to silo working. Jones et al also suggest 'improved interagency working might also assist in moving from individual to collective responsibility/accountability for combating DVA and lead to more embedded systemic change'.

5.36 Training was an issue arising from another recent DHR in Norfolk, and as a result the county Domestic Abuse & Sexual Violence Board has set up a task group to review and evaluate domestic abuse training across the county. They have developed a set of standards to ensure consistency in the quality and content of training to all agencies, and this work continues at the time of this review.

Resource Shortfalls

5.37 Key agencies, particularly the Police and Adult Social Care were, and still are at the time of this review, experiencing challenges in meeting demand for their services due to a shortfall in staffing and the availability of experienced staff, GPs also face constraints with time limit appointments and challenges in undertaking face to face appointments. This was exacerbated by the challenges of Covid restrictions during part of the period under review. Inevitably this affects services' response, especially to complex cases, for example pressures on time and difficulties finding information on the Adult Social Care case recording data base are just a few.

5.38 Resource shortfalls are outside the scope and influence of the DHR. However, it is important to highlight the ramifications for cases such as Doris who required time and expertise to recognise the risk she was facing and to take action to mitigate that risk.

6. Recommendations from the Review:

6.1 The following recommendations arise from agencies IMRs, Panel discussions and from the lessons learnt from the Review.

Panel Recommendations:

National Recommendation 1 – To overcome the disparity in definition of domestic abuse under which the Police, CPS and other criminal justice agencies operate, and the definition used for convening a Domestic Homicide Review (which includes 'a member of the same household'), consideration should be given by the Home Office and Ministry of Justice to aligning definitions to achieve a common working definition.

Recommendation 2 – That the Liquid Logic case management system provider should review the LAS case management system and ensure that an immediately accessible chronology of referrals, major events, and safeguarding incidents are easily visible for practitioners.

Multi-Agency

Recommendation 3 - All agencies involved in this review should ensure that information provided by family members is given importance and status in assessments, is accurately recorded, shared appropriately, and thoroughly investigated where concerns are raised for a person's safety. This should be monitored in supervision and reinforced in agency practice guidance.

Recommendation 4 - Safeguarding Adult Board & Community Safety Partnership - All relevant agencies in the county should:

a) Audit their safeguarding training and confirm that awareness and identification of 'cuckooing' and the steps to take when it is identified is included in the course materials.
b) Evidence that this review is included, and remains integral, in training as an anonymised case study to highlight the vulnerability of older adults to raise awareness that 'cuckooing' can take place outside of 'county lines' and 'trafficking' cases.
c) Evidence procedures are in place for staff to follow which includes instructions for working with cases involving 'cuckooing' of a vulnerable person who is a homeowner, and in such situations, they must convene a multi-agency strategy/professionals' meeting to construct a safety plan for the victim which includes the consideration of legal injunctions to remove the person who has moved in and stayed against the owner's wishes.

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These actions to be put in place within 6 months of completion of the review.

Recommendation 5 – To produce effective fully informed risk assessments agencies should take steps to promote a culture of multi-agency working and the value of a coordinated multi-agency approach (including improving the use of professionals' meetings) to risk assessments. This should be imparted by managers in team meetings and supervisors in supervision and advice sessions. It should include utilising opportunities for shared learning events and/or multi-agency training programmes for staff at least once per year.

Recommendation 6 – All agencies raising a safeguarding concern to the local authority should ensure the documentation submitted contains all relevant background information held on the subject/s particularly information necessary to inform risk assessments such as physical or mental health vulnerabilities, substance misuse, and/or offending history.

Recommendation 7 – All agencies involved in undertaking assessments of concerns and of a safeguarding nature, or which require the assessment of risk, should be reminded to ensure their practitioners:

a) Demonstrate professional curiosity and ask open probing questions when gathering information to inform assessments.
b) Make detailed and accurate records which include examples of incidents or behaviours raising concerns or which indicate risk.
c) Are supported and guided by management to fully probe risk levels and avoid premature closing of cases.
d) Audits of safeguarding concerns and referrals should take place annually to ensure that holistic information has been gathered from a range of sources to fully inform risk assessments and the progress of the case.

Recommendation 8 – To address deficits in understanding and application of the Mental Capacity Act it is recommended that agencies:

a) Review and develop Mental Capacity Assessment (MCA) training for the Norfolk partnership workforce to support full and effective assessments of capacity.
b) The training must include assessment of mental capacity, recognition of the various impacts of coercive control a person's mental and physical wellbeing, and their ability to freely make decisions in their best interests.
c) The evaluation of the training must provide measurable outcomes which demonstrates the workforce understand, apply, and have confidence in using the MCA and the ways in which coercive control affects capacity.

Recommendation 9 – The Norfolk Safeguarding Adults Board should produce and publish a clear and updated organogram which clearly articulates current safeguarding terminology, roles, responsibilities, and processes.

Recommendation 10 - The Norfolk County Community Safety Partnership should work with key stakeholders (e.g. Norfolk County Council) to ensure that all publicly available information (including websites) relating to the MASH is accurate and current.

Adult Social Care

Recommendation 11 – Adult Social Care should ensure all safeguarding referrals are assessed as per the Care Act 2014 definition of an 'adult at risk' to include: (a) is experiencing, or is at risk of, abuse or neglect, and (b) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it, in addition to (c) has needs for care and support (whether or not the authority is meeting any of those needs), taking account of all available information from agencies and family members.

Change Grow Live

Recommendation 12 - When staff have concerns about domestic abuse, but the risk assessment does not meet the MARAC referral level, staff should be reminded and empowered by managers to make a MARAC referral based on 'professional judgement'.

Individual Management Review Recommendations:

Norfolk Police

Recommendation 13 – Training input to be included to all frontline officers to help them recognise adults at risk and understand the impact of cumulative risk – case example arising from this review to be used. To be drafted into a training slide by the safeguarding development team with immediate effect. Success will be measured with a dip sample of incident logs and APIs to be conducted by the MASH Detective Inspector.

Recommendation 14 – An automated triage tool to be developed to address the backlog of APIs, to prioritise risk in the backlog and to recognise repeat victims. Current multi-agency processes to be reviewed to understand thresholds and ensure information is shared with support services, either within the MASH or on districts with adults at risk, depending on potential harm or abuse and frequency. Success will be measured with a dip sample when the triage tool is in place and cases are being prioritised based on risk. Quality assurance checks to ensure that OPTs or MASH services are being made aware of appropriate APIs.

Recommendation 15 – Norfolk Police to create a referral mechanism between MASH and EHH/OPT when cases do not fit the criteria for safeguarding within the MASH. Current processes will need to be reviewed. It would likely be an internal process within Police systems. Success would be measured by having a formal process to pass regular information between MASH & OPT/EHH structures within each district.

Recommendation 16 – When previous convictions of potential perpetrators are relevant to the risk presented to the adult at risk, details to be shared with other agencies to help them form safeguarding plans and further support in appropriate cases.

Recommendation 17 – Training slides to be added to the vulnerability training day to show the importance of recording details of safeguarding advice and action. This will be done by the safeguarding development team. Exact details of advice and action taken to be recorded appropriately to assist those trying to secondary safeguard, including partner agencies. It

would also provide a log of actions and advice that has been tried and tested when trying to problem solve repeated issues.

Adult Social Care

Recommendation 18 - That Adult Social Care reminds its practitioners that they must be clear about the decision that needs to be made when mental capacity is being considered.

Recommendation 19 - That managers at Adult Social Care ensure mandatory training (particularly DASH) is carried out and that the learning and development team sets up a system to monitor whether mandatory training has been completed.

Recommendation 20 – That the ASC quality assurance team audits whether practitioners are reviewing, consolidating and summarising information on cases at least once a year so that information is easier to find for practitioners reviewing records when a safeguarding concern is raised.

Recommendation 21 – That the ASC quality assurance team to audit whether SCCE are clearly stating why a face-to-visit is necessary and whether this advice is followed by locality teams.

Recommendation 22 – ASC practitioners are reminded to review the record of the person alleged to be the cause of risk/harm when taking a safeguarding concern and considering raising a referral.

Recommendation 23 - To remind ASC practitioners to contact the Police for information if there is a concern about a potential criminal history of an alleged perpetrator so that an accurate picture of risk can be established.

Recommendation 24 – ASC to work with the Police to ensure information-sharing about the criminal history of alleged perpetrators is completed when raising safeguarding concerns with ASC.

Recommendation 25 - To remind ASC managers about the need to carry out regular caseload supervision and reflective case discussions with teams and individuals. This will provide support and guidance and promote a culture of curiosity.

Norfolk and Waveney Integrated Care Board (on behalf of the respective GPs)

Recommendation 26 - Norfolk and Waveney ICB to commission training for primary care professionals specific to mental capacity act and appropriate functional assessment of mental capacity and feedback to be collected from attendees.

Probation Service

Recommendation 27 – Staff completing initial sentence plans in cases where the person on probation is not engaging should be based on previous information, Crown Prosecution Service document and liaison with other agencies for information. This will support a fully informed risk assessment and risk management plan.

Recommendation 28 - Initial sentence plans should not be countersigned by line managers unless the above actions have been undertaken and there is a comprehensive risk assessment

and risk management plan. This will ensure that risk assessments and sentence plans adhere to organisational standards.[23]

Recommendation 29 - At pre-sentence report stage, there should be Police intelligence checks completed to inform both the pre-sentence report and the initial sentence plan. If for any reason these checks have not been completed, the allocating manager will set an action for this to be undertaken. This will ensure that risk assessments and sentence plans are fully informed and relevant safeguarding actions are undertaken.

Recommendation 30 - In the event that there is poor compliance during community sentence, a Police intelligence check should be undertaken to establish if there are any additional safeguarding actions that need to be undertaken.

Recommendation 31 - In the event that there is poor compliance during the period of probation supervision, Probation staff should firstly establish whether there are any other agencies involved in the case by undertaking MASH checks. Once these details are obtained, probation staff should liaise with relevant agencies and work collaboratively to re-engage the person on probation and to manage risk.

Recommendation 32 – Cases that are not complying i.e. in breach of Community Orders/Suspended Sentence Orders and are registered as homeless should have a management oversight discussion and entry put onto case records to ensure all required steps are undertaken to manage risk.

James Paget University Hospital

Recommendation 33 – All staff to be reminded of the importance of applying the principles of routine enquiry during interactions with patients.

Great Yarmouth Borough Council

Recommendation 34– GYBC to work with partners to ensure that clearer guidance / training is provided by MASH and MARAC to all of its partner agencies to include:

a) An explanation of the roles and processes of the MASH and MARAC.
b) The correct referral route for staff to take when they have concerns about an individual to enable staff that work for these agencies to understand when to use each type of referral mechanism.

And that GYBC to work with partners to ensure that a clear differentiation between MASH, MARAC, etc. be provided to all partner agencies to enable staff that work for these agencies to understand when to use each type of referral mechanism.

Change Grow Live

Recommendation 35 - Workshops to be held in each locality as part of local Integrated Governance Team Meetings to explore professional curiosity to ensure staff are confident to use proactive questioning to understand what is happening with an individual and or family.

[23] These two recommendations (28 and 29) are implemented by Senior Probation Officers as part of the organisational countersigning framework. Sentence plans are also subject to internal auditing processes including quality assurance undertaken by Quality Assurance officers. His Majesty's Inspectorate of Prisons and Probation will be undertaking an inspection of the East of England Probation region in early 2024. Suffolk Probation practise will be inspected as part of this process.

East of England Ambulance Service NHS Trust

EEAST did not identify any recommendations arising from their limited contacts with Doris and Chris.

APPENDIX 1

Comment from Laura, Doris's daughter:

The various legislation that surrounds the safeguarding of adults exists to protect the human right to be free from abusive and inhuman treatment, and ultimately the right to life. They are not just procedures to follow, or to be avoided or ignored (as was the case multiple times in the failure to protect my mum), but enablers for professionals with responsibility to uphold human rights, to do so.

Every single time there is a review (that I am aware of) into what went wrong when authorities failed in this duty I hear the term 'professional curiosity'. The image that often comes to mind is that of a jigsaw puzzle. You can only see the whole picture if all of the pieces are in place (although admittedly certain individual pieces should suffice to take urgent action to safeguard life). When I think of the 16 months leading up to my mums murder I see a relatively simple puzzle. One that even a small child could solve. With large pieces that were presented time and time again to all agencies involved. What will haunt me for the rest of my life (and I have found no real answers in reading the various agency responses) is how on earth that simple puzzle was never put together.

I do not accept (as set out in the draft DHR report), that the police officers who visited my mum in the 16 months leading up to her murder, used professional curiosity. In fact, I would go as far as to say that it was the complete lack of curiosity that characterized their response. They showed concern, especially in the early days of the abuse. I spoke to an officer who sympathized with me, said he would not want his mother living with that man. But curiosity. No. There were, however, many missed opportunities for curiosity (Laura's full statement – see Appendix B).

The police could have asked whether the fact that my mum kept letting him (the perpetrator) back in the house after episodes of violence and fear, was indicative of the personal nature of their relationship, or indicative of the coercion that became increasingly obvious. This really matters because Chris's abuse of my mum followed a pattern I know now to be typical of domestic abuse. In particular he became over time, increasingly entitled to my mum and her property.

The police could have asked the question whether my mum inviting this younger 39 year old man into her home was indicative of her cognitive frailty…. my mum was 82 at the time, she had never called the police to her house previously, so these incidents were not typical of my mum. They were out of character. The police could have understood Chris's behaviour as part of a pattern. As I know now he had moved into the homes of people previously and become violent when asked to leave. He had also been violent to women on multiple occasions.

They knew Chris was a violent person and considered him a risk to themselves (I know now they visited in at least pairs for this reason there were four the night she was murdered), yet did not consider the risk he posed to the 82 year old disabled woman he had moved in with. I say this not because they didn't ask him to leave the house on many occasions, they did, but that they held my mum responsible for the decision to let him back in again. I struggle to understand why, given the history and context, the police would have thought he wouldn't return. The review mentions the police not letting family know about his criminal history. I would settle for them just taking it seriously themselves.

Continued….

The local authority has the legal duty to take whatever action is necessary to protect a person from harm if they are at risk of abuse and unable to protect themselves. They did not even visit my mum. They told me, during the frequent safeguarding concerns I raised articulating the escalating risk, they had visited my mum and she said she wanted him there. They said this even though they didn't visit. They said this even though my mum had asked them, in at least one call, for help to get him out (I found out later, through the DHR). They did not tell me that in that call they said to my mum, when she asked for help to get him out, that she should get her family to help and she said, in response, that her family are scared of him. They did not tell me this even after I told them on two separate occasions that I was scared he would kill her, and that, in a later referral, the indifference of agencies was emboldening him.

And in my last referral, that sad, desperate time when my mum really wanted him gone, when his so called tenancy agreement had shifted the dynamics of the relationship so that he no longer felt he needed to be nice to stay there, the local authority officer did not even bother to call and speak to her over the phone.

Was it just me? Was there something about how I communicate, how I speak, that means I am not taken seriously. For most of my professional life I have been an advocate. My job has been the articulation of voices, of rights, of risks. I am now a safeguarding lead. I train staff across our organization to understand and articulate risk in all the deeply hidden ways it can at times manifest. Was there something about me? I really don't think so. I am a good communicator. I don't get angry I just get clear. I am skilled at fighting my way, intellectually speaking, through the fog. So, what stopped me being heard? Was the comment that the GP (who had never spoken to me) made that the 'daughter probably overstates things' just saying out loud what everyone was thinking? Again, I don't think so. Not only because I am a good communicator, but because it wasn't only me raising the alarm. Concerns came from many agencies, police, housing, ambulance, even my mums plumber raised safeguarding concerns.

Nothing good can come of this review if it does not involve a proper acknowledgement of the deep and catastrophic failings that led to my mum's murder. And they did lead to my mum's murder. It might have been Chris who committed that appalling act that night in July, but that monster was made by the repeated indifference of so many agencies. By the repeated, and I can find no other word for it, doggedly determined failure to see the risk that my mum was in, to put the pieces together, to look at the picture that was, by the time of her death, screamingly obvious. This is all I have left. There is no way that I can ever come to terms with what happened to my mum that night. Not least because I will never actually know what happened to her. Ensuring that her death will bring about meaningful change is all I have.

Laura's full unabridged statement can be found in the Overview Report at Appendix B