DOMESTIC HOMICIDE REVIEW
and
SAFEGUARDING ADULTS REVIEW

OVERVIEW REPORT

Into the death of Doris

July 2021

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

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

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.

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GLOSSARY

AP – Assistant Practitioner

API – Adult Protection Investigation

ASSD – Adult Social Services Department

DHR – Domestic Homicide Review

DASH/DARA – Domestic Abuse Stalking Harassment/Domestic Abuse Risk Assessment – both forms of risk assessment for domestic abuse

EEAS – East of England Ambulance Service

GDPR – General Data Protection Regulations

GYBC – Great Yarmouth Borough Council

ICB – Integrated Care Board

LAS – LiquidLogic Adult Social Care Data System

MHA – Mental Health Act

MCA – Mental Capacity Act

NCC – Norfolk County Council

NSAB – Norfolk Safeguarding Adults Board

NSFT – Norfolk and Suffolk NHS Foundation Trust (Mental Health Services)

SCCE – Social Care Community Engagement

SCCE AP – Assistant Practitioner working in the Social Care Community Engagement Team

SAPC – Safeguarding Adults Practice Consultant

SW – Social Worker

S42 – section 42 of the Care Act (relates to safeguarding adults)

SARs – Safeguarding Adults Reviews

Adult Social Care Job titles and explanation of roles

Deputy Safeguarding Adults Board Manager –

- Scale L post. Reports to and deputises for the Norfolk Safeguarding Adults Board Manager. Manages LSAP activity, writes and communicates much of the Board's practice guidance and procedures.

Eastern Locality Director of Operations –

- Scale O post within the integrated part of the adult social care structure. Provides senior leadership for Eastern locality and reports to the Director of Community Health and Social Care Operations. Manages the locality's Team Managers.

Safeguarding Adults Team Manager –

- Scale L post. Manages the Safeguarding Adults Practice Consultants. Provides operational management for the safeguarding team and safeguarding support to the wider department.

Safeguarding Adults Practice Consultant –

- Scale K post at senior social worker level. Specialist safeguarding role offering consultation and management overview for safeguarding cases, to front line staff in both SCCE and locality teams. Contribution to safeguarding planning discussions to support with multi-agency discussions about safeguarding actions and management of the most complex safeguarding enquiries which often involves oversight of whole provider concerns.

Social Care Community Engagement Assistant Practitioner –

- Scale G post based in adult social care's front door service. SCCE APs will respond to calls received in the Customer Service Centre which have been triaged by a manager for urgency. They gather further information and can make assessments under the Care Act for some low complexity cases. They gather details and put cases through to locality teams where the situation is more complex and needs a face-to-face visit and these decisions are made under the supervision of a manager. They provide advice, information and signposting. They take safeguarding referral information and discuss with managers and SAPCs about whether s42 enquiries are needed.

Social Care Community Engagement Service Manager –

- Scale M post with operational leadership oversight of Social Care Community Engagement and line management of the 3 team managers.

Preface

The joint Domestic Homicide Review and Safeguarding Adult Review Panel and the members of the Norfolk County Community Safety Partnership Board would like to offer their sincere condolences to Doris's daughter, grandchildren, great grandchildren, and friends for the untimely loss of a very important person in their lives.

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The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. Doris's death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance[2] under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

> (a) a person to whom he/she was married, in a civil partnership, in an intimate personal relationship, a parental relationship in relation to the same child, a relative or
> (b) a member of the same household as himself.

Section 44 of the Care Act 2014 stipulates that Safeguarding Adults Boards (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b)condition 1 or 2 is met.

(2) Condition 1 is met if—
(a)the adult has died, and
(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—
(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Following a referral from the NCCSP to the Norfolk Safeguarding Adults Board (NSAB) in January 2022, it was determined by the NSAB in March 2022 that the case met the criteria for a Safeguarding Adults Review (SAR).

[2] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2016) Section 2(5)(1)

1. Domestic Abuse Act 2021: Definition of "domestic abuse"[3]

(1) This section defines "domestic abuse" for the purposes of this Act.

(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—
(a) A and B are each aged 16 or over and are personally connected to each other, and
(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—
(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse (see subsection (4));
(e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—
(a) acquire, use, or maintain money or other property, or
(b) obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Under the **Domestic Abuse Act 2021**, two people are considered **"personally connected"** to each other if any of the following applies:

1. They are, or have been, **married** to each other.
2. They are, or have been, **civil partners** of each other.
3. They have agreed to **marry** one another (whether or not the agreement has been terminated).
4. They have entered into a **civil partnership agreement** (whether or not the agreement has been terminated).
5. They are, or have been, in an **intimate personal relationship** with each other.
6. They each have, or there has been a time when they each have had, a **parental relationship** in relation to the same child (see subsection (2)).
7. They are **relatives**[1].

Although the nature of the relationship between the victim and perpetrator in this case has not been fully resolved, the definition of domestic abuse is presented here as the victim had disclosed a sexual / intimate relationship with the perpetrator to her daughter and granddaughter in the period prior to her death. Although agencies were aware of this disclosure, when questioned, the victim denied that their relationship was sexual / intimate. This factor will be discussed further in the overview and analysis of this review.

[3] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacte

DOMESTIC HOMICIDE REVIEW / SAFEGUARDING ADULTS REVIEW

1. Introduction

1.1 This joint report of a Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) examines agency responses and support given to Doris,[4] a resident of Great Yarmouth District prior to the point of her homicide in July 2021. The review will consider agency contact and involvement with Doris and the perpetrator of her homicide Chris[5], from June 2020 to July 2021. This period was determined by the DHR panel to cover the period Chris became known to Doris.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking an holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 This review follows the murder of Doris in the county of Norfolk in July 2021. Inquiries show that Doris had accommodated a homeless person (Chris) some 13 months prior to the homicide. Police were frequently called to Doris's address in the months prior to the murder in response to Chris's abusive and violent behaviour. On the evening before the murder, Doris fled her home and called Police from a neighbour's home as Chris was drunk and abusive. On attendance, Police removed Chris from Doris's home and advised Chris that he would be arrested if he returned. At some point early the following day, Chris returned to Doris's home and violently attacked her, resulting in her death.

1.4 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process; this remains the responsibility of individual agencies.

Timescales

1.5 This review began with a first Panel meeting on 31 March 2022, was concluded in October 2024, and was signed off by the CSP Partnership Board on 11 December 2024. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. Due to ongoing criminal proceedings which did not conclude until May 2023, it was not possible to meet this timescale. The criminal proceedings affected the Panel's consideration of Individual Management Reviews from agencies. Parallel agency reviews also impacted the Panel's work.

[4] Doris is the pseudonym chosen for this review by the victim's daughter.
[5] Chris is the pseudonym chosen for this review by the DHR Chair and Author.

Confidentiality

1.6 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.

1.7 To protect the identity of the parties involved and their family members pseudonyms have been used in the review, The victim's daughter chose the following pseudonyms for this review:

- Victim – 'Doris'
- Victim's daughter – 'Laura'
- Victim's granddaughter – 'Chloe'

1.8 The victim's grandson chose his own pseudonym, 'Jack'.

1.9 The Chair and Author chose the pseudonym 'Chris' for the perpetrator after checking with Doris's family that this had no connotations in their family.

1.10 The victim in this case was aged 83 years at the time of her death.
The perpetrator was aged 42 years at the time of the offence.

1.11 Both parties in this review were White British.

Terms of Reference of the Review

1.12 **Terms of Reference for the Review: Domestic Homicide Review Statutory Guidance Section 2(7) states 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.

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 June 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 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 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 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 (or 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 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. 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 perpetrator to remain in the home was invoking 'inherent jurisdiction' 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 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 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 2020 onwards 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 Service 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?

22. Did agencies in contact with Doris and Chris consider the potential for Chris to be 'cuckooing' Doris at any time? Are staff trained to recognise 'cuckooing'? Did the staff in contact with the Doris and/or Chris, or in a supervisory position have training and knowledge of 'cuckooing'?

23. Are there any similarities between the facts, themes, or learning from this review arising from prior local DHRs or SARs?

24. Have any examples of effective practice been identified in this case?

Methodology

1.13 The Norfolk County Community Safety Partnership (NCCSP) chair was informed by the Police of the fatal incident on 27 September 2021, and in consultation with partners at a decision-making panel[6] meeting on 21 October 2021 it was determined that the circumstances met the criteria for a Domestic Homicide Review to be

[6] 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.

undertaken. The Home Office was notified of this decision the same month. The Chair and review Author were appointed in December 2021.

1.14 Following a referral from the NCCSP to the Norfolk Safeguarding Adults Board (NSAB) in January 2022, it was determined by the NSAB in March 2022 that the case met the criteria for a Safeguarding Adults Review (SAR).

1.15 A total of 11 local agencies were initially scoped by the NCCSP to establish which services had been involved or had contact with the parties in this review. A total of 3 agencies reported no contact, and 8 confirmed contacts with either victim or perpetrator and were then asked to secure their files. Following contact with the victim's daughter in March 2022, additional information was sought from, and provided by Cambridge City Council.

1.16 Following the appointment of the Author and Chair in December 2021, those agencies confirming their involvement were asked to provide a chronology of their contacts. These were subsequently combined by the review Author to form the narrative chronology within this review.

1.17 In February 2022, the Chair and Author met with Doris's daughter, Laura, to discuss the draft Terms of Reference for the review. At this meeting, Laura advised that she had made two separate complaints to the Independent Office for Police Conduct (IOPC) relating to Police action on the day before her mother's death and also the response of Norfolk Police officers to a concern for Doris's welfare (raised by Laura) in the period immediately after her murder. The IOPC's report was shared with the review's Chair and Author by Laura in April 2023 and the findings have been incorporated into this review.

1.18 At the first Panel on 31 March 2022 the draft Terms of Reference were discussed. As the Panel learnt that the Norfolk Safeguarding Adults Board (NSAB) had judged the circumstances met the requirement for a Safeguarding Adult Review, it was agreed the Terms of Reference would be taken to the Safeguarding Adults Board to assess whether additions were required to meet their procedures. The Terms were agreed by the NSAB in May 2022.

1.19 In April 2023, and following the conclusion of Police investigations, the review Chair, Author and a panel member viewed Police body-worn video footage relating to the final Police call out to Doris's home to determine her, and the perpetrator's, demeanour in the hours prior to Doris's murder. A second panel was also convened in April 2023.

1.20 The following month, May 2023, the review Chair attended the perpetrator's sentencing hearing at Norwich Crown Court. Psychiatric reports submitted to the trial were requested by the review Chair at this time. Notes from the sentencing hearing and information from the psychiatric reports has been included in this review.

1.21 In July 2023, the Chair and Author interviewed the victim's granddaughter, grandson, and the perpetrator's mother. Details of these meetings are given in the following section.

1.22 In September 2023, the Chair and Author interviewed Chris in prison. Details of this meeting are presented in the 'overview'.

1.23 Following the fourth panel meeting in January 2024, additional information came to light regarding Chris's contact with Herring House (a local provision for single, homeless individuals).[7] Herring House was contacted and submitted a brief report on their involvement to the review. Additional panels were convened in June and July 2024.

1.24 A further panel became necessary in October 2024 after what was expected to be the final meeting held in July 2024 due to ongoing discussions regarding final recommendations and action plans. There were 7 panels meetings in total.

Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.25 The Chair, Author and panel members are most grateful for the contributions of Doris's family to this review. The information provided by Doris's daughter, granddaughter and grandson have provided vital context to the records held by agencies in this case.

1.26 The Chair, Author and panel members are also most grateful for the contribution of the Chris's mother to this review. The information provided by Chris's mother has provided vital context to the records held by agencies in this case.

1.27 Doris's daughter, Laura, was written to by the Community Safety Partnership in February 2022 to advise that a DHR had been launched and that a Chair and Author had been appointed. This letter contained details of the local DHR process.[8]

1.28 Also in February 2022, the Chair wrote a letter of introduction to Laura requesting a meeting to discuss the draft Terms of Reference. This letter contained the relevant Home Office DHR and Advocacy After Fatal Domestic Abuse (AAFDA)[9] leaflets.

1.29 The Chair and Author met with Laura at her home in March 2022. During this meeting Laura agreed the draft Terms of Reference and added a number of her own questions to the Terms. Laura also consented to a referral to AAFDA for specialist advocacy through the DHR process. This referral was made by the review Chair the same month and an AAFDA advocate supported Laura during the DHR.

1.30 In April 2022, the Community Safety Partnership again wrote to Laura to advise that the Norfolk Safeguarding Adults Board had accepted that the facts of the case warranted a Safeguarding Adult Review and that this review would run in conjunction with the DHR.

1.31 In July 2023, the Chair invited Doris's granddaughter, Chloe, and grandson Jack via email to contribute to the review, and both accepted. The Chair and Author met with Chloe, and Jack separately via ZOOM, the same month. During the meetings specialist independent advocacy via AAFDA was offered and further details of the service was sent to them via email by the Author. Regular email and telephone updates took place between Laura, the Chair and Author during the course of the review, and Laura attended a virtual panel meeting in November 2023, where interim updates and initial findings were presented.

[7] See: https://www.herringhousetrust.org.uk/
[8] www.norfolksafeguardingadultsboard.info/domestic-violence-review/
[9] Advocacy After Fatal Domestic Abuse (AAFDA) a specialist charity providing support to families including throughout the DHR process.

1.32 The draft report was shared with Laura, Chloe and Jack in February 2024 via recorded delivery, and Doris's family were invited to provide feedback. The Chair and Author met with Laura in March 2024 to collate her and Chloe's thoughts and comments on the draft.

1.33 What was intended to be a final panel meeting took place in July 2024 and this was attended by Laura, Chloe, and the family's AAFDA advocate. They were updated regarding the need for an additional panel and following the October 2024 meeting, they were informed when a draft of the report had been sent to the Coroner.

1.34 Following the conclusion of the criminal trial, the Author of the review wrote to Chris's mother in June 2023 to determine if she would like to engage with the review. This offer was accepted, and at Chris's mother's request the Chair and Author spoke with her via a telephone call in July 2023. Chris's mother requested a transcript of the meeting, and this was forwarded to her along with the notes of the meeting for her agreement, by mail. Chris's mother was also offered specialist independent advocacy via AAFDA at this time.

1.35 In September 2023, the Chair and Author interviewed Chris in prison to gain his perceptions of services offered to him prior to the fatal incident and if anything could have been done differently by agencies in contact with him, and Doris.

1.36 The contributions detailed above have informed the 'background', 'overview', and 'analysis' sections of this review.

Contributors to the Review

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

- Norfolk Constabulary
- Norfolk County Council Adult Social Care Services (to cover all ASC teams)
- James Paget University Hospital (JPUH)
- GPs for Doris and Chris (via the Integrated Care Board, or ICB)
- Great Yarmouth Borough Council (GYBC)
- Suffolk Probation Service (NPS)
- Change Grow Live (CGL)
- East of England Ambulance Service NHS Trust (EEAST)
- Herring Housing provided a brief report
- Cambridge City Council Housing Department provided information.

1.38 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.

The Review Panel Members

1.39 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:

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[10]	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)	Assistant Service Manager NIDAS
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[11]	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

[10] Two meetings only to update the Panel.

[11] 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/

Chair and Author of the Overview Report

1.40 The independent chair of this Review is Gaynor Mears, OBE. The independent author is Simon Kerss. Both have over 20 years' experience working at practice and strategic levels in the domestic abuse sector. They have not worked for, and are independent of, agencies within the county of Norfolk. They have both attended Review chair/author training and have individually undertaken DHRs in other areas in addition for the Norfolk County Community Safety Partnership previously. Their full experience for their respective roles can be found at Appendix A.

Parallel Reviews

1.41 An IOPC investigation was opened in February 2022 following two complaints from the victim's daughter. This investigation concluded in January 2023 and the results of the investigation have informed this review.

1.42 A Coroner's Inquest was opened and adjourned in May 2023.

1.43 This Review is a joint Domestic Homicide Review and Safeguarding Adult Review.

Equality and Diversity

1.44 The Equality Act 2010 places a duty on local authorities to eliminate unlawful discrimination, harassment, and victimisation; to advance equality of opportunity between people who share a protected characteristic and people who do not share it; foster good relations between people who share a protected characteristic and people who do not share it. The protected characteristics covered by the Equality Duty under Section 4 of the Act are: age, disability, gender reassignment, marriage and civil partnership (but only in respect of eliminating unlawful discrimination), pregnancy and maternity, race which includes ethnic or national origins, colour or nationality, religion or belief which includes lack of belief, sex, and sexual orientation.

1.45 Agencies in this case did not consider Doris and Chris's relationship to be intimate (even though Doris's family were told by her that this was initially the case, and this information was shared with agencies by Laura and Chloe) and so did not conceptualise or respond to the relationship as one of domestic abuse. However, by the definition established in Section 2: 5 (b) of the DHR statutory guidance (2016) that DHRs should be conducted when 'the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by…a member of the same household' as themselves, the Review Panel have found that, for the purposes of this review, the academic and practice-based literature around domestic abuse and domestic homicide is most relevant in contextualising Doris's experiences.

1.46 Throughout the review, the Review Panel identified that the protected characteristic of sex required specific consideration. National datasets[12] show that the majority of domestic homicide victims are female, and the majority of perpetrators are male. This characteristic is therefore relevant for this case as the victim of the homicide was a woman and the perpetrator of the homicide was a man.

[12] Office for National Statistics: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022#domestic-homicide

1.47 The Review Panel also identified that the protected characteristic of age required specific consideration, given that Doris was aged 83 years at the time of her death. Research[13] shows that older women are typically at a higher risk of harm from domestic abuse as they may be unwilling to share sensitive information; be less likely to seek support; and are more likely to have a disability. It is of note the most recent census data (Office for National Statistics (or ONS), 2021), shows Norfolk has a higher proportion of over 64-year-olds (24.4%) compared to the England percentage of 18.4%.[14] This fact has future implications for all service providers in the area notably the need for all agencies to be alert to identifying domestic abuse where older people are concerned and having appropriate support services for them.

1.48 The most recent ONS data (March 2021) also shows that between the year ending March 2018 to the year ending March 2020, the highest proportion of domestic homicide victims were aged 70 years and over; nearly one in five (or 18%) of the total. Again, this has implications for local service providers in future.

1.49 The Equality Act defines a disability as a physical or mental impairment that has a substantial, adverse, and long-term effect on a person's ability to carry out normal day-to-day activities.[15] The condition must be deemed to last more than 12 months, and the focus is on the effect of the physical or mental health problem, rather than the diagnosis. Although there was no full assessment of Doris's capacity in this case, the Review Panel further identified that the protected characteristic of disability required specific consideration, given that Doris's mobility was impaired, and it was suspected by her family that her mental capacity was also impaired. Research[16] shows that disabled women are significantly more likely to experience domestic abuse and this intersection with age is likely to result in increased risk of significant harm.

1.50 A prior analysis of Safeguarding Adult Reviews (SARs) (Local Government Association, 2020)[17] found that 'self-neglect', 'neglect', 'physical abuse', and 'financial/material' abuse were the most prominent abuse types cited in the 231[18] SARs analysed for victims aged 70 – 89. The majority of this abuse was perpetrated against victims in their own homes. The analysis also found abuse types such as 'psychological / emotional abuse' and 'modern slavery' were more prominent issues for females, than for men. In one of the SARs analysed 'neglect' was more specifically conceptualised as physical abuse and neglect/omission being centrally involved, "possibly associated with emotional abuse, including coercive and controlling behaviour, and sexual abuse." In Doris's case, it is known that Chris was coercively controlling, psychologically / emotionally violent and was financially

[13] Safe Lives, 2016. Safe Later Lives: Older people and domestic abuse. Available online at: https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse. And Age UK, 2020. No Age Limit: the blind spot of older victims and survivors in the Domestic Abuse Bill. Available online at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/age_uk_no_age_limit_sept2020.pdf.

[14] See: https://www.norfolkinsight.org.uk/population/#/view-report/63aeddf1d7fc44b8b4dffcd868e84eac/___iaFirstFeature/G3

[15] See: https://www.mind.org.uk/information-support/legal-rights/disability-discrimination/disability

[16] See: https://wearehourglass.org/domestic-abuse

[17] Local Government Association, 2020. Analysis of Adult Safeguarding Reviews: April 2017 – March 2019. Available online at: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019

[18] This figure included 12 murders. A total of 4 convictions resulted from these cases.

abusing her. Certain aspects of Chris's behaviour whilst resident at Doris's address (such as walking around naked) are also considered by the Review Panel to be evidence of sexual abuse. The most recent data, based on an analysis of 652 SARs (Local Government Association, 2024) and presented in a 'practitioner briefing'[19] ahead of the full report being published later in 2024, finds that domestic abuse was a factor in 16% of the SARs reviewed; with physical abuse constituting 14%; and financial abuse a further 13%. With regards to practice gaps identified in the briefing, it was determined that:

> *The most commonly noted practice shortcomings were poor risk assessment/risk management (noted in 82 per cent of cases), shortcomings in mental capacity assessment (58 per cent), and lack of recognition of abuse/neglect (56 per cent). Also frequently highlighted were shortcomings in making safeguarding personal (50 per cent), absence of professional curiosity (44 per cent) and attention to people's care and support needs (43 per cent), mental health needs (41 per cent) and physical health (37 per cent). An absence of professional curiosity (44 per cent) meant that circumstances were sometimes taken at face value rather than explored in detail. Other commonly found shortcomings included absence of legal literacy (40 per cent), superficial acceptance of individuals' apparent reluctance to engage (38 per cent), absence of a 'think family' approach (37 per cent). Poor recording, poor attention to unpaid carers, lack of understanding of personal history, absence of trauma-informed practice, shortcomings in hospital discharge and poor attention to living conditions were each found in around a quarter of cases. Observed less frequently but nonetheless having a negative impact were a lack of perseverance (21 per cent), poor access to advocacy (21 per cent), lack of attention to substance use (20 per cent), poor transition planning (15 per cent), poor attention to protected characteristics (12 per cent) and absence of relationship-based practice (10 per cent).*

1.51 The Review Panel were also cognisant of the role that Doris's religious beliefs may have played in the events leading to her death. Doris was a practicing Chrisitan and was active in her local church. Doris initially took pity on Chris's homeless status and offered him accommodation as a consequence. Research shows that although deeply held religious beliefs can constitute a protective factor in cases of domestic abuse (Drumm, et al., 2014), they can also inhibit help-seeking activities (Mulvihill, et al., 2022).

1.52 Recent national research (Home Office, 2021) into the context of domestic homicides show that issues relating to mental health and substance misuse are the most frequently cited vulnerabilities with regards to perpetrators of domestic homicide. In Chris's case, the Review Panel were aware that he claimed to have mental health problems but could find no specific diagnosis to support this claim from his recent records. The panel were also aware that Chris was known to misuse illicit substances and alcohol but felt that this misuse did not constitute a disability. Psychiatrists at Chris's trial found no causal link between his mental health and culpability. They also found insufficient evidence to show mental disorders were relevant in his defence. Had Chris been treated as an Adult at Risk in his own right by relevant agencies, the Review Panel may have been able to form different conclusions with regards to potential Equality and Diversity considerations. However, considering information received via agency IMRs and in light of evidence

[19] See: https://www.local.gov.uk/our-support/partners-care-and-health/safeguarding-resources/analysis-safeguarding-adult-reviews-4

presented at his trial, the panel have not identified any specific issues relating to protected characteristics regarding Chris, other than to note his vulnerabilities / risk factors associated with the perpetration of domestic homicide.

1.53 With regards to any barriers which may have prevented Doris or Chris accessing specialist domestic abuse services, this rests primarily with the fact that, despite information being provided by Doris's family to the contrary, no agency conceptualised Doris's and Chris's relationship as intimate / sexual, and so no local domestic abuse policies were followed in this case. This issue is discussed more fully in this review's 'analysis'.

1.54 With regards to barriers to Chris accessing support for his mental health issues, he was not considered by agencies in this case to be an Adult at Risk in his own right, and so no referrals were made which may have helped address this safeguarding issue. With regards to Chris's substance misuse, he was referred to Change Grow Live for specialist support but chose not to engage fully with this provision.

Dissemination

1.55 In addition to Doris's family, the following will receive a copy of this review:

- Members of the Norfolk County Community Safety Partnership
- Office of the Police and Crime Commissioner for Norfolk
- The College of Policing
- Domestic Abuse Commissioner for England & Wales
- Secretary of State for Health & Social Care
- Secretary of State for the Home Office
- Secretary of State for the Ministry of Justice
- Organisations represented on the Panel
- Norfolk Safeguarding Adults Board
- Suffolk Safeguarding Adults Board.
- Norfolk Criminal Justice Board

2. Background Information (The Facts)

2.1 Doris had lived in her home in which she was killed since 1991. Following the death of her husband, and then her two adult sons in 2016 and 2019 respectively, she had lived alone until meeting Chris who was homeless at the time. Family members surmise that Doris felt sorry for Chris and provided him with accommodation in her home sometime in June 2020. At this time Doris told her daughter and granddaughter that she and Chris were in a sexual relationship and planned to marry. Agency records reflect this disclosure from Doris's family, but the information was not corroborated during interventions with Doris. Later it appears that Doris took on more of a 'motherly' role. As the months past Chris's behaviour became more controlling, erratic, and financially abusive of Doris. He drank excessively and used illicit drugs. Her family became increasingly worried and contacted various agencies raising safeguarding concerns.

2.2 Periodically, Doris had enough of Chris's behaviour and took steps to remove him from her home, either by calling the Police, or approaching local housing providers for alternative accommodation which Chris did not follow up. Chris devised a tenancy agreement witnessed by one of his relatives and used this to insist he had a right to remain when the Police were called.

2.3 One evening in late July 2021, Doris left her home to seek support from a neighbour as Chris was being abusive towards her. Police were called by the neighbour, and 4 officers attended. Police removed Chris from the premises and advised that he would be arrested if her returned. As Doris's house keys were missing, Police advised Doris to secure her back door by wedging a chair up against the handle. They then left the premises. A further Police 'drive-by' check was made later that evening, but Chris was not seen by officers at this time.

2.4 The following morning, Doris's daughter, Laura, called Police to raise concerns about her mother's whereabouts. Following further contacts by Laura where she again raised concerns for her mother, Police attended and found no sign of Doris and she was raised as a high-risk missing person.

2.5 Chris was arrested the same month (July 2021) and charged with Doris's murder (he denied all charges against him).

2.6 At Chris's trial in March 2023, it was determined that he had murdered Doris.

2.7 Expert testimony at the trial found no causal link between Chris's mental health and culpability for the murder. There was insufficient evidence to show mental disorders were relevant in this case. There was also insufficient evidence to show whether he was intoxicated at the time of the murder. The murder was judged to have been for gain. Chris had become aware that Doris had changed her Will which had previously benefited him.

2.8 At trial, Chris was convicted of murder and arson. In May 2023, he was sentenced to life imprisonment with a minimum tariff of 35 years. He will serve 33 years (taking into account the 662 days spent on remand) and the judge said he must only be released if deemed safe to do so by the Parole Board.

2.9 A Coroner's Inquest into Doris's death was opened, and adjourned, in May 2023.

Further Background Information for Context

The victim: Doris

2.10 In addition to the information provided by Doris's daughter Laura in her pen portrait of her mother at the start of this review, the information provided by Doris's granddaughter Chloe and grandson Jack provide valuable context about their grandmother and highlights her vulnerabilities. They also provide context concerning Doris's relationship with Chris.

2.11 Doris's granddaughter, Chloe, described her 'nanny' as having 'differing versions' of herself over time. Chloe explained how as a younger child she would spend 'fun' weekends with Doris at the local zoo, or playing in her garden, but that Doris 'suffered a lot' after her husband died and she was prone to depression. She said Doris was somewhat shy and introverted at this time.

2.12 Chloe went on to describe Doris as becoming 'extrovert' in her behaviour around 10 years ago. She said Doris would seek out and speak with 'anyone' and this behaviour became more extreme over time, especially when Doris did not agree with the opinion of others. Chloe felt Doris had 'lost a part of herself' in terms of this

personality change and was less able to appropriately handle social situations as a result. Chloe also reported that Doris had issues with her mobility and balance and would often become startled and dizzy if someone passed too close to her on the pavement. Chloe believed this dizziness had resulted from a 'growth on her brain' diagnosed by a scan following a fall. Chloe described how Doris grieved following the death of her two sons [in 2016 and 2019] and did not like being alone.

2.13 Chloe felt that Doris's personality did not appear initially to change after she met Chris. She did, however, say that Doris's personal relationships suffered after meeting Chris as Doris only wanted his company. She felt that Doris 'needed' Chris to 'mother'.

2.14 She also felt strongly that Chris manipulated Doris's kindness towards him, and he was 'always there' and listening in on telephone conversations. She said that Chris did not like her mother, Doris's daughter, Laura, and would 'feed her [Doris] negative thoughts about' the family.

2.15 Chloe described how she initially 'felt sorry' for Chris, as her mother Laura, had said that Chris was being bullied and harassed by local teenagers when he was homeless and living in a tent. However, at their first and only meeting in Doris's garden, Chloe related how she immediately felt uncomfortable in Chris's presence as he was staring at her and made a comment about how attractive she was. He also referred to the garden as 'ours', which Chloe said, 'didn't feel right at the time'. Chloe described how Doris had picked up on her discomfort and had asked Chris to go inside and leave them alone. Following this meeting with Chris, Chloe told her mother about her discomfort around him.

2.16 Chloe defined the relationship between Doris and Chris as 'sexual' during the first few months. Chloe recalled that Doris had told her during a phone call that she was being intimate with Chris and 'despite my age, I still need sex'. Laura, Chloe's mother, had also mentioned to Chloe that Doris and Chris were being intimate at this time. Neither approved of the relationship, but Chloe felt that Doris was 'flattered' by Chris's sexual relationship with her.

2.17 She went on to explain that the sexual element of Doris and Chris's relationship 'didn't last that long' and the relationship 'changed' after the period of intimacy. She felt Doris was 'keeping a lot' from the family, but from the way she spoke about Chris, Chloe felt that Doris now 'felt sorry for him' and was acting as a 'mother figure'.

2.18 Chloe told us that she was concerned for Doris and she and Laura would speak every day about 'what was going on'. She added that Laura had all the contact with agencies relating to Chris and Doris, but Laura would tell Chloe about events as they arose.

2.19 Chloe advised that Doris had kept up her frequent contact with a local church group, but towards the latter stages of her relationship with Chris had used this group as a means of 'getting away from him'. She said Doris had told her that she was becoming increasingly frustrated with Chris as he 'would break things'. Doris had also told Chloe she very much wanted her family and Chloe's child to visit her, but Chloe advised Doris that she would not visit Doris's home whilst Chris was present and did not want Doris to visit her home in case Chris found out where she lived.

2.20 Chloe explained she felt a 'pivotal point' in Doris and Chris's relationship revolved around the 'tenancy agreement'[20]. From this moment, Chloe noticed a change in Chris's demeanour and behaviour towards Doris. Prior to this, Chloe felt, Chris 'had to be nice' to Doris to remain in her home, but afterwards he 'became his true, arrogant self' and acted as though he 'had a right to be there'. Chloe felt this change in Chris's behaviour resulted in Doris no longer wanting him to stay in her home and expressed frustration that 'this piece of paper' had no legal basis but was used by Chris to convince agencies that he was entitled to live with Doris. She felt as though 'everyone [agencies] knew it [the 'tenancy agreement'] didn't mean anything', but agencies were 'using it to allow him [Chris] to get back in'.

2.21 Chloe concluded that the 'entitlement' Chris felt due to agency inaction around the 'tenancy agreement', coupled with her mother's inability to secure action from local agencies against Chris to 'get him out of the house', directly led to her grandmother's death. She said that agencies had just 'stopped talking to us' and hadn't 'taken things seriously'. Consequently, Chloe felt Chris had 'just stopped caring [about potential repercussions]' and that agency inaction had emboldened Chris and worsened his behaviour towards Doris in the period prior to her murder.

2.22 Doris's grandson, Jack, also told us that his grandmother had 'changed a lot' following the death of one of her sons in 2016. He described her as 'incredibly outgoing, happy, and trusting to a fault'. Jack described how Doris would 'give money to those who needed it', and would strike up relationships with wild animals, such as 'Jeffrey the Seagull'. Jack described how his 'nanny' would often call him to chat, but these calls would be at any time of day or night. Jack especially remembered how Doris called him at 7am one morning thinking it was 7pm in the evening. He recalled the frequency of these calls reduced when Chris 'moved in'.

2.23 Jack described how 'terrible' Doris was with money as she would often forget how much she had spent from her pension, her deceased husband's pension, and her Personal Independence Payment. He reported helping Doris set up savings and cash accounts, and he introduced her to online banking. Jack found that allocating Doris a cash allowance helped her to better manage her finances; Doris had taken out loans but had struggled to repay these. He felt the loan companies had 'taken advantage' of Doris at this time. Jack also talked of how Doris had become involved with an organisation [now known as Bakker Prize Promotions], who he felt was exploiting Doris and encouraging her to spend more money than she could afford in the hope that she could win a significant cash prize. Jack explained the above financial arrangements stopped when Chris moved in with Doris; Chris had set up another current account for Doris – one to which Jack had no access, so was not able to monitor. He went on to report that Doris would give Chris 'money for things', leaving herself without cash.

2.24 Jack described how he had never physically met Chris but had initially 'wanted to help' as Chris was homeless and had recently been attacked by a gang of youths. He had contacted Shelter on Chris's behalf and had given Doris information on accommodation to be shared with him. Jack expressed concerns about Chris's influence on Doris, especially relating to 'anti-vax, Covid stuff'. Jack described how Doris would call him to talk about the importance of being vaccinated (against Covid), but would then discuss this with Chris, who 'turned her around'. Doris would then call Jack back to dissuade him from being vaccinated.

[20] Chris drew up a tenancy agreement himself and had asked his mother to witness it. It was not a formal tenancy agreement put in place by Doris setting out an official landlady/tenant arrangement as would normally take place for example via a Shorthold Tenancy Agreement.

2.25 Jack recalled an incident when he had called the Police on Doris's behalf following an argument with Chris. He explained that Chris had left the house and Doris had not wanted him to return and he had called the Police to advise them of ongoing issues rather than requesting any immediate action. Doris had asked Jack 'not to tell' Jack's mother, Laura, about the call, nevertheless Jack had shared this information with his mother. At this time Jack was aware that Chris made his mum and sister feel 'unsafe'.

2.26 Jack also told us that when he spoke with Chris on the phone, Chris would 'ramble' and 'yell' and was 'not someone you could have a conversation with'. Jack also remembered a time when he called Doris and Chris answered. Jack described Chris 'walking around naked, talking about his 'peacock'', and how this had made him feel very uncomfortable. He also recalled a further conversation with Chris wherein Chris was defending paedophilia and he had compared the persecution of paedophiles as akin to the persecution of Oscar Wilde. In a separate conversation, Chris had also spoken about cannibalism and suicide in a way which disturbed Jack.

2.27 Jack recalled the last time he spoke with Doris was 2 or 3 weeks before her death. He concluded that 'there was a lot of helplessness around the situation [with Chris]. He and his mother Laura had both said, 'what if he is going to kill her to get the house?' You know, those kinds of things just don't happen in real life. It felt like we had no real way of safeguarding against that, and then the worst thing happened. It felt like wherever we reached out to, we couldn't get anything done. I just want to see a change where people can properly safeguard someone. My mum works in safeguarding, and even she couldn't get anything done'.

2.28 Records of an Occupational Therapist (OT) assessment following a home visit to Doris in January 2019 held by Adult Social Care note Doris was a sociable, open, and proactive lady who demonstrates insight and adaptability around her health and functional needs. Doris resided alone in her privately owned four-bedroom detached house. She had cerebella ataxia that impaired her standing, walking, and coordination. Doris had a history of falls but not recently. She required the assistance of 2 walking sticks when mobilising internally to support her balance, she had low blood pressure and depression. Doris shared with the OT that she experienced a constant and chronic pain in her left knee due to an arthritis, but there was no planned surgery for the knee. Doris was perceived as a proactive lady who demonstrated insight regarding her needs.

The perpetrator: Chris

2.29 Chris's mother described his childhood in Norfolk as a happy one. Chris was an accomplished pianist, who had reached Grade 8 by the age of 11 years. Although somewhat solitary and 'quirky' by nature, he enjoyed the company of other musicians and was involved in the local music 'scene'. As a young person, Chris frequently attended church with a relative and enjoyed the sense of community this provided.

2.30 Chris's mother told us that his behaviour began to change at the age of 13 or 14, when he became noticeably anxious around others and would often shout and make strange noises during school lessons. He also began to drink alcohol frequently at this age. Due to these changes in behaviour at 14 years Chris was referred to a psychiatrist. On attending, Chris's mother explained what the problem was, and the psychiatrist asked to speak to Chris on his own, Chris was to make the short

distance home on his own. Chris's mother described how he arrived home shortly after herself and said the psychiatrist had prescribed Prozac for him but had offered no further support. This appointment, Chris's mother felt, was the first time Chris had been let down by services which she, and Chris, had hoped would address his mental health needs. She also felt that prescribing a 14-year-old child with Prozac[21] in the absence of a parent was irresponsible, and Chris would often not take his medication, or would take 3 tablets in one go.

2.31 She also reported that Chris became a 'handful' in his later teenage years as he began to drink heavily. Despite this, Chris had attended university to study music production where he entered into a relationship with a female student who became pregnant with his child. Shortly after the pregnancy was terminated, the relationship ended, and Chris dropped out of university and returned to Norfolk where he found a job and his own accommodation.

2.32 Chris began to drink more heavily and to use drugs at this time. His mother described how 'people of all ages' would visit Chris's home to use alcohol and drugs, and she would frequently find his home 'smashed up'. She also described how Chris became more paranoid when he drank alcohol, and that she felt uncomfortable when he would bring his 'friends' to her home. Chris's mother told us that she was unable to access appropriate support for him at this time, and that GPs in the area 'just didn't want to know'. She described Chris as a 'ticking time bomb', who was at risk of harming himself. Chris's mother felt that the only time Chris was supported was after he had been 'sectioned' (confirmed via NFST records as having occurred in 2009), but this support was withdrawn shortly after he was released from hospital. She also described a time when she had called the local mental health crisis team after Chris had 'smashed everything' in his home but had been told no-one was able to visit him.

2.33 Chris's mother explained how he was unable to access any local GP surgeries as they could not offer him supervised appointments.[22] Subsequently, she explained that Chris's GP was based in Ipswich, Suffolk, and Chris was unable to attend appointments there because of the distance involved; Chris's prescriptions would be sent by the GP to a local pharmacy where he would pick them up.

2.34 Chris's mother went on to tell us that she had met Doris on 'many occasions' and would frequently visit her at her home to chat 'over tea and cake'. She felt that Doris genuinely enjoyed Chris's company and would listen to him play the piano. She described Doris and Chris as 'good friends' who made each other laugh. She also described Doris as 'vulnerable' and was concerned that Chris was drinking heavily, not sleeping, and apt to wander around in the night whilst he was living with her. She had told Doris that if things with Chris 'got too much, then he would have to go'.

[21] Prozac is also known as Fluoxetine, which is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It is often used to treat depression, and sometimes obsessive-compulsive disorder and bulimia. See https://www.nhs.uk/medicines/fluoxetine-prozac/about-fluoxetine/.

[22] Supervised appointments of this sort are known as Special Allocation Scheme (SAS) appointments. 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-patient-assigned-to-the-special-allocation-scheme/.

2.35 She also reported that Doris would give Chris money to buy alcohol. She was aware that Doris's daughter (Laura) was unhappy with Chris living with her mother and told us of a telephone call between Laura and herself wherein Laura had asked if Chris could move back home with his mother. Chris's mother had told Laura that both Chris and Doris were 'consenting adults' and that such a request would not encourage Chris to move. We were also told how Chris had presented his mother with a tenancy agreement that he had drawn up to codify living arrangements with Doris. Although Doris 'seemed happy with it', Chris's mother described the document as 'not worth the paper it was written on' and, when asked, had declined to sign it as a witness.

2.36 Overall, Chris's mother felt that Chris had been let down for many years by local agencies. She expressed her own frustration that she had been unable to secure support for him, and that her primary concern was that Chris would harm himself or take his own life; he had self-harmed in the past. She said that she had 'never envisaged that he would murder someone' and described Chris as 'a desperate young man for most of his life'.

2.37 Agency records prior to the timeframe under detailed review show that Chris was well known to criminal justice agencies in both Suffolk and Norfolk (including being supervised by the Suffolk Probation Service between 2009 and 2020) and had warning markers on Police systems for use of weapons, suicide, self-harm, use of drugs, and mental health. As such, Police were required to 'double crew' call outs involving Chris.

2.38 Adult Social Care (ASC) records regarding Chris pre-date his meeting Doris. Case notes show a call from the Police to the Emergency Duty Team reporting Chris's detention in Northfield Hospital under s136 of the Mental Health Act[23] in 2004 aged 24 years. He was on bail following an allegation of rape. However, no evidence of mental illness was diagnosed, and he was discharged to live with his grandparents. His father visited a Social Services office in 2005 regarding his son's behaviour. Information noted an accusation of rape by a woman, and sexual harassment by a woman both of whom he worked with. It was recorded Chris could be aggressive and verbally abusive but is described as not being violent. Previously arrested for drunken behaviour. His father was considering having him to live with him. He was advised for Chris to seek medical advice with a possible referral via the mental health link worker, and to call Police if Chris was violent towards his grandparents (paternal) with whom he was currently living.

2.39 In 2014 Adult Social Care (ASC) received two requests for assessments for Chris, one from the Police one from Nelson House reception. Both were connected to his mental health and homelessness. One referred to an altercation with a fellow resident where he was staying at the time.

2.40 During 2017 ASC had 11 contacts regarding Care Act assessments for Chris. These were made by Probation, Mental Health, and Criminal Liaison.

2.41 Records from Chris's GP show he was detained under the Mental Health Act (1983) for 14 days in 2009, following a suicide attempt.

[23] Section 136 of the Mental Health Act 1983 gives the Police the power to remove a person from a public place when they appear to be suffering from a mental disorder to a place of safety. The person will be deemed by the Police to be in immediate need of care and control as their behaviour is of concern.

2.42 Two Initial Sentence Plan risk assessments were undertaken with Chris by Suffolk Probation Service in August 2019, but on review, both were found to be blank. A further risk assessment was undertaken in Chris's absence in September 2020, but again details relating to the risks posed to others by him were absent.

2.43 Norfolk Police records show that Chris had 121 crime investigations recorded on the Athena database for the period 2015 to 2021, with him being either a victim or a suspect. He also featured in two non-crime domestic incidents assessed as 'low-risk' with an ex-partner in 2017. In one incident Chris was recorded as the victim, and in the other as a suspect of assault occasioning to actual bodily harm.

2.44 After the above relationship concluded, Police records show that Chris became known as a street drinker and part of the homeless community. He reported 9 incidents of members of the public being violent towards him and he was also a suspect in 6 incidents of violence towards others. Chris was a named suspect in 10 previous incidents of dishonesty offences such as theft and fraud. He was known to be verbally abusive, threatening, and to have caused damage to property with 12 such incidents being recorded. He had been found on occasions to have drugs in his possession and bladed articles such as scissors and ice picks when stopped by Police.

2.45 Chris was also a suspect in two separate sexual touching offences against children which occurred in public places. This resulted in community tension, and he became the victim of several assaults and verbal abuse from members of public.

2.46 Early in 2019, Police records show Chris had threatened to shoot his previous landlady and burn down her home. The victim in this case did not want to support a Police prosecution and so Chris was given words of advice about his behaviour.

2.47 In March 2019, Chris's GP referred him to the Access and Assessment Team for mental health input. He was assessed by a senior mental health nurse within Norfolk and Suffolk NHS Foundation Trust (NSFT) in June 2019. The assessment concluded that Chris was not suitable for mental health services because 'he has approximately 20 closed referrals and latterly is mostly seen when in Police custody.' It was felt he was not suitable for therapy at any stage in the future because 'he was not interested in attending groups and it was not felt that it would be safe for him to participate in these.' Chris was discharged and signposted to Change, Grow, Live alcohol services.

2.48 In November 2019, Chris befriended a vulnerable male adult and moved himself into his home address. Police recorded an Adult Protection Investigation (API) which detailed 'concerns for this male'. He wanted Chris to live with him, as he needed help with care. In January 2020, Police were called to the address as Chris had tipped a bucket of urine over the male and was shouting and swearing at him.

2.49 Between August 2019 and April 2021, Chris was convicted of further offences on seven separate occasions. Suffolk Probation Service records indicate that there were no further pre-sentence reports prepared during this period.

2.50 In April 2021, Chris was sentenced to a Suspended Sentence Order with no requirements. He was therefore not required to have any contact with Probation staff following this date.

3. Chronology

3. 1 The first date agencies were aware that Chris was living in Doris's home was on 11 June 2020 when Police records state that '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 record, for which there is no source, concludes with 'NFI' (no further information). There is a further record on 19 June reaffirming the above information, and another record from 3 July stating that Chris was residing in Doris's shed, with her permission.

3. 2 On the 11 June 2020, the Probation Service recorded that Chris failed to attend a telephone appointment. Chris also failed to attend a telephone interview with Probation on 1st July and 8th July.

3. 3 Doris had engaged with a debt management charity, StepChange, since March 2018. The first StepChange record (23 November 2018) stated Doris had approached them due to her 'taking out high interest loans for home improvements.' Doris's vulnerabilities are evidenced in the StepChange records, and she continued to have the support of the charity to manage the debts assisted by her daughter Laura (note: it was confirmed in a meeting between the Chair, Author, and Laura in March 2024, that it was Jack who actually supported Doris with her finances). An assessment undertaken on 17 June 2020 by the charity recorded:

> *Clt suffers from Cerebellar Ataxia. Clt has also recently had an accident that limits the clt's mobility. Clt needs to take taxis and uses this service every day. Clt already has daughter as Authority on the account and the daughter said that no further help was needed at the moment. Clt aware we can signpost if needed. When speaking to authority, no further adaptation to the call needed to be made.*

3. 4 Records from the James Paget University Hospital (JPUH) for 20 June 2020 show Chris attended Accident Emergency (A & E) following an alleged assault 'some days ago by a number of people'. Chris presented with a swollen and bruised nose at this time. He was discharged with pain relief and referred to the ENT (Ear, Nose and Throat) clinic for '3/4 days'' time. The following day, 21 June, Chris again attended the A & E at JPUH with 'generalised weakness, severe pain' but discharged himself before being assessed. He was seen at the ENT department on 23 June, where he disclosed taking Methadone[24] and drinking 1 litre of gin or port per day. Chris was seen again at the ENT clinic on 25 June, following which he was discharged.

3. 5 On 29 June, Laura called StepChange on behalf of her mother. The record for this call states:

> *Client advised clients mum is vulnerable and a victim of crime her partner has been stealing from her and is an alcoholic. With her consent I alerted the act as she insisted her mum can be quite vulnerable.*

[24] 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

3. 6 Probation records show that Chris appeared at Great Yarmouth Magistrates' Court on 8 July 2020 where he was charged with the following offences:

31/03/2020 - Contravene requirement as to restriction of movement during emergency period - Coronavirus - NG Plea
08/04/2020 - Contravene requirement as to restriction of movement during emergency period - Coronavirus - NG Plea
08/04/2020 - Contravene requirement as to restriction of movement during emergency period - Coronavirus - NG Plea
08/04/2020 - Act as a pedlar without a pedlar's certificate - Guilty Plea Proceedings to consider a criminal behaviour order
These matters were adjourned to the same court until 2nd October 2020.

3. 7 On 13 July 2020, Probation wrote to Chris scheduling a telephone appointment for the 15 July. Chris did not attend this meeting, and a further letter was sent to him rescheduling a telephone appointment for the 22 July. This appointment was not kept, and a further appointment letter was sent the following day for a telephone appointment on 5 August.

3. 8 Probation records show that Chris failed to attend a scheduled appearance at Great Yarmouth Magistrates' Court on 29 July 2020 for the alleged offence of common assault relating to an incident on 5 March 2020. A 'warrant not back for bail' was issued by the Court at this time. The following day, 30 July, Probation records show that Chris appeared at Norwich Magistrates' Court for a breach of a community order, and for the alleged offence of common assault relating to the incident on 5 March 2020. The case was adjourned until 16 September 2020 to 'tie in with other matters.' Probation and the Courts were not aware of Chris's change of address at this time.

3. 9 Police records show on 5 August 2020, officers attended Doris's home following concerns raised by Laura, Doris's daughter, regarding the presence of Chris in her mother's home. The concern raised by Laura was that Doris had invited Chris to move into her home some two months previously as she was concerned that he was 'sleeping rough'. Laura was also concerned that Doris was suffering from early onset dementia, and that she could 'lack capacity'. Further information from Laura was that her mother had told her that Chris was frequently drunk and 'will then act strangely as pretends he is a dog and will walk around naked'. Laura also advised Police that her mother had told her 'several months ago' that Chris 'would touch himself over his clothing in front of her' and that 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'. The Police enquiry log (dated 6th August) shows that this information was shared with Adult Services 'for their review and consideration or further necessary actions, or support and services for which the parties may be eligible'. A further enquiry log (dated 7 August) shows that Doris was spoken to by officers in the presence of Chris on 5 August. This record states that Doris was 'happy to let us in' and told officers that she had 'previously kicked Chris out as he walked around naked, and she didn't like that'. The same record states that Doris had 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'. It is not clear whether officers spoke with Chris at this time, but they advised Doris that they 'may pop in to see her now and again' – an arrangement 'she was happy with'.

3. 10 Probation records show that Chris failed to attend his scheduled telephone appointment on 5 August, and that a further letter outlining an appointment for 12 August was sent to him the same day.

3. 11 Records from the Norfolk Multi-Agency Safeguarding Hub (MASH)[25] show that the Police Adult Risk Assessment relating to their attendance at Doris's home on 5 August 2020 was received on 6 August. The risk assessment received by the MASH stated:

> *Officers Justification for level of Risk: Doris. 2 months ago she has invited Chris to stay with her at her h/a after she has seen him sleeping rough.*
> *I have been made aware of situation by Chris coming into the Public Enquiry Office (PEO) to report an unrelated matter. He has stated that he is currently staying at above with Doris who is 83 years old.*
> *Doris is an elderly lady who lives alone. I have contacted her daughter who has raised concerns over these living arrangements as believes that Doris could have early onset of dementia and is worried that she could lack capacity. Doris has told her that Chris will frequently become drunk and will then act strangely as pretends he is a dog and will walk around naked inside the home address. Doris has told her several months ago that Chris will touch himself over his clothing in front of her and that on numerous occasions they have engaged in sexual intercourse with one another. Doris has told her that she plans on marrying Chris and leaving him the house. Her daughter has been trying to arrange a doctors [sic] appointment regarding concerns over Doris's mental wellbeing; however they have last seen Doris one month ago and deemed Doris to have capacity - at present they have said they cannot make a full assessment unless Doris agrees to this.*
> *Her daughter states Doris lives independently and can take care of herself well; however in recent years she has had to help her mother sort out the bills/financial decisions etc. I have advised daughter to make contact with doctors and ask for an assessment at home for Doris. On speaking with Doris over the phone, she can engage well in conversation and does not seem confused, etc. I have asked about the situation with Chris, and she states that he has been staying with her for the past two months at which she is happy for as this gives her some company which is helping since the recent death of her son. She stated she asked Chris to leave a few weeks ago after he became drunk and was playing the piano too loudly. I have asked her whether she has had any issues with Chris staying there to which she has said she has not and enjoys him being there.*
> *Her daughter has no further concerns regarding him being there - for example no concerns over financial exploitation as she takes care of finances, etc. Her main concern is that her mother is engaging in a sexual relationship with Chris if she does lack capacity.*
> *I have advised Doris to call us should she have any issues.*
> *Daughter has advised that she visits her mother regularly so will report if there are any issues.*
> *HOMELESS MALE HAS BEEN STAYING AT ADDRESS OF ELDERLY LADY FOR PAST 2 MONTHS AND THEY HAVE SINCE BEEN ENGAGING IN A SEXUAL RELATIONSHIPS CONCERN THAT FEMALE HAS EARLY ON SET OF DEMENTIA.*

[25] Multi-Agency Safeguarding Hub

There is a further Police record dated 6 August confirming that Chris had been living with Doris for 'the past two months.'

3. 12 As a result of the Police referral to MASH on 6 August, a practitioner from the local Social Care Community Engagement team (SCCE) contacted Doris, by phone. During this conversation, the SCCE records state that Doris's 'only issue' with Chris was that he needed somewhere to live and support with 'getting him off the alcohol'. In response to these concerns, Doris was advised that Chris needed to contact his GP and Great Yarmouth Borough Council (GYBC). The SCCE records also state that Doris was independent and not requiring any support around the house. The record also shows that Doris had stated that she was 'happy' that Chris was staying with her as she enjoyed the company, and she felt safe and unthreatened by him. 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. As a consequence, the practitioner deemed there were no further actions for Social Care.

3. 13 On 12 August, Chris failed to attend his scheduled appointment with Probation.

3. 14 Police records show that on 16 August 2020 Police were made aware by Laura that Chris had been 'shouting at Doris' and that she no longer wanted him staying with her. This record shows Doris had left Chris's belongings outside of her home, and she 'believed he had headed to the beach'. No further actions are recorded by Police at this time.

3. 15 On 29 August, Chris called 111 stating he believed he was having a heart attack. Ambulance Service records for this date state:

> *Patient admits to drinking a lot of alcohol every single day, Patient has no fixed address but currently staying at a lady's house. Patient states has been stressed lately suffers with mental health issues has had this problem in the past that's been investigated and put down to anxieties. Patient states it's not a pain. Patient is a very manic person a whirlwind in behaviour and speed. Patient declined transport to hospital.*

3. 16 Records from the JPUH A & E department show that Chris attended on 30 August 2020 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 at this time but was 'deemed not to have a mental illness'. No further enquiries regarding Chris's home situation are recorded, and there is no evidence of any safeguarding considerations, risk assessment or onward referrals from practitioners at A & E or the mental health liaison team. Further records relating to Chris's A & E visit on 30 August state he had discharged himself 'before review' and left when he spotted hospital security staff. The record goes on to state Police were called by staff at JPUH to undertake a welfare check with Chris.

3. 17 Police records for 1 September 2020 show concerns for Doris's wellbeing were raised by her granddaughter who advised the Police that Doris had asked Chris to leave her home 'before', but Doris 'then asks him back' (note: it was clarified during a meeting with the Chair, Author, and Laura in March 2024 that it was actually Jack (Doris's grandson) who had raised this concern). The record for this event also states, 'they are not in nor have been in any relationship'. The record goes on to state Doris had told Chris 'he is like a child' and he had taken offence to this and 'slit his wrists' as a consequence. Doris's granddaughter went on to report Chris

had received treatment for these wounds, and Doris had again invited him back into her home. The Police enquiry log entry for 2 September states Doris had advised Police (presumably by phone, though the nature of this contact is not recorded) that she intended to ask Chris to leave her home and intended to have her daughter's help with this. The log shows Doris was 'advised about what to do and to call Police if she needs advice'. 'Safeguarding advice' was also given to Doris at this time, although there are no further details as to the nature of this advice. The record for this event concludes there were 'no concerns Chris is taking advantage of…' Doris, but it is unclear as to whether it was Doris or the Police officer who provided this opinion.

3. 18 On 3 September 2020, Chris attended JPUH by ambulance and a blood test was undertaken. He was then discharged.

3. 19 Adult Social Care (SCCE) received a 'safeguarding contact' at the MASH from Police on 6 September 2020 after the event described above outlining Doris's granddaughter's concerns. This was followed on the same day by a telephone call from SCCE to Doris. During this call, Doris stated that Chris was in the house, but not in the same room as herself. SCCE enquired about calling back at another time, but Doris declined this offer. Doris advised SCCE that Chris had an appointment with Great Yarmouth Borough Council housing department on 10 September, and he was 'a laugh', treated her like his mother, and called her by her initials. It is recorded that Doris further advised SCCE she was not scared of Chris, and he had never been violent towards her, although she did say that 'I hit him and call him fatty' (a statement which the practitioner noted and recorded 'it did not sound like she caused him harm'. She further reported the only time she had been fearful was when Chris had 'slit his wrists'. In this conversation, Doris also described Chris as 'childlike' as he spent 'all day swimming in the sea, bowling and drinking cider', and she reiterated that Chris was an alcoholic. 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.

3. 20 Also on 6 September, a practitioner from SCCE made a telephone call to Laura. During this conversation, Laura advised that 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 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 that 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 also 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 – confirmed by Police), 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 on the fact 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.

3. 21 On the same day as the SCCE contact with Laura (6 September 2020), the SCCE practitioner called Doris's GP to discuss concerns raised by the Police. During this call, SCCE records show that the GP stated that 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'. Additional records for the same date confirm they had no evidence of dementia or cognitive impairment relating to Doris. Information from Laura around this date suggests that Doris had suffered a head injury, but the GP records do not reflect this.

3. 22 Laura again contacted SCCE 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.

3. 23 Records from SCCE show this discussion took place via a telephone call between SCCE and the MASH SAPC on the same day as the telephone call with Laura (14 September). The SAPC advised the SCCE practitioner 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'.

3. 24 On 15 September 2020, SCCE called Doris to discuss the issues described above. There was no response from Doris on this occasion, but contact was established, via telephone, the following day (16 September). The record from SCCE states that Doris did not recall the contact with SCCE the previous week. Doris was asked about the circumstances of Chris living with her, to which she replied, 'he's alright here, he's quite fun really'. 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. The SCCE practitioner revisited questions with Doris regarding her care and support needs during this conversation, but the records record that Doris reported she was independent and did not need support. 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.

3. 25 Later in the day on 16 September 2020, Doris called ASSD and spoke with a customer service worker. During this call, Doris advised that Chris was 'street homeless' and that he had been living with her for some 6 months. Doris stated during this conversation, that she did not want Chris living with her, and he was 'often in trouble with the Police'. She added that Chris had mental health issues and self-harms. The record states the 'referrer [Doris] said she is not scared of him and does not feel at risk from him', but that she wanted him to leave her property. 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.

3. 26 The day after Chris's appearance at court (17 September 2020), Doris again 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 that 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. The practitioner provided the phone number for GYBC to Doris and advised her that they suspected that Chris had called them (SCCE) from her home telephone number the day before. Following the call to SCCE, Doris called the Police stating she didn't 'want him [Chris] living in her house anymore.' Doris added that when she had brought up the fact that she had contacted GYBC about Chris's housing situation, he [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. Police records show that Chris's belongings were left in Doris's shed, and they ensured he did not have a key for the property. A CAD (Computer Aided Dispatch) marker was placed on the address at this time, and records were updated to reflect this the following day (18 September). 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.' The record does not state who provided this update to Police.

3. 27 On 22 September, a SCCE practitioner discussed Doris's case with the MASH SAPC. During this conversation it was agreed Doris had capacity 'around the Care Act outcomes' and there was 'no role for safeguarding at this stage'. The actions arising from this meeting were to advise the Police that 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. The SCCE practitioner called Laura the same day to discuss the decision to close the case. The record shows that Laura 'disputed' the decision and requested a Care Act assessment for her mother. During this call, Laura advised that her mother had been falling victim to financial 'scams' and she would be 'lost without help'. Laura further reported her mother was afraid of Chris when he was drunk and would often lock herself in her bedroom to avoid him. She also 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.' The SCCE practitioner responded by saying they would discuss the case again with their manager and suggested Doris could have a Care Act assessment to establish her needs and capacity. The action arising from this discussion was for SCCE to call Laura the following day with an update.

3. 28 The discussion between the SCCE practitioner and the MASH SAPC took place the same day (22 September 2020). The SCCE practitioner advised the SAPC that there was now an allegation of Chris 'being directly emotionally abusive' towards Doris and Laura felt as though Doris may be eligible for care needs. The action arising from this discussion was for the SAPC to speak to Doris regarding the allegations of verbal abuse, and to try and establish a date for this event. The records state if there proved to be insufficient evidence to raise a section 42 safeguarding enquiry, then Doris's case would be transferred to the Eastern Locality Team for a Care Act assessment. 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.

3. 29 As a result of the action described above for the SAPC, an Assistant Practitioner (AP) also called Doris and Chris on 22 September. The call recorded on this date related to safeguarding concerns raised for Doris and also the referral Doris had made for Chris for support with housing. The two issues were assigned to the same AP in SCCE because both related to Doris's wish for Chris to leave her property. However, the records show the AP (North) first spoke with Doris, who advised she would like Chris to move out before Christmas. The AP then spoke with Chris and provided advice around his benefits entitlement. Chris told the AP he thought he was on a 'Government blacklist' which was preventing him from securing accommodation. The AP recorded Chris 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'. Chris told the AP he and Doris were getting on 'famously' though they 'have ups and downs like anyone else' and that '95% of the time we have a good time'. As a result of this conversation, the AP provided Chris with the ASSD telephone number and advised him to call if he needed support. The record shows the AP discussed this call with a Practice Consultant, who 'agreed no further action' based on the understanding that Chris did not have needs for care and support under the Care Act. The action arising from this discussion was for the referral to be closed. Also on 22 September, Chris attended a routine Endocrine Clinic appointment at JPUH.

3. 30 The following day, 23 September 2020, the SCCE practitioner called Laura with an update regarding the decision reached with the AP the previous day. 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 as Laura's called to SCCE, 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.

3. 31 Also on 23 September 2020, SCCE received from the Police a 'POLICE SAFEGUARDING Referral Form: Risk Level - Medium Assessment - ADULT_RISK_ASSESSMENT' dated 6 September highlighting concerns regarding Chris's behaviour. The form submitted by the Police described contact with them by Doris's granddaughter on 1 September raising her concerns about Chris who was staying with her grandmother who had taken him in to give him a bed and he had ended up staying for quite some time. The form included:

- *They are not in nor have been in any relationship.*
- *Doris has told Chris that he is like a child and he has taken offence and her granddaughter believed and has then slit his wrists.*
- *He has got treatment for this and Doris then let him back in. Chris had refused to say why he had slit his wrists.*
- *Doris is planning on asking him to leave again and she is going to get her daughter to help.*
- *She has been advised about what to do and to call Police if she needs advice*.

The referral form did not include any of Chris's relevant offending history.

3. 32 This referral was discussed by the SCCE practitioner with the MASH SAPC. The outcome of this discussion was a Section 42 safeguarding enquiry would not be raised as 'there was not enough evidence of abuse or care and support needs.' The

action arising from this discussion was for the case 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. A further action was for the assessor to discuss any concerns arising from the assessment with the locality SAPC. Following this discussion, the SCCE practitioner called Laura to advise that a safeguarding assessment would not be undertaken with her mother, but a Care Act assessment would be undertaken by the locality team. The following day, 24 September, Doris's case was allocated to the locality team and was triaged. The decision of this triage was to 'allocate for a visit rather than complete a duty visit', and the record shows Doris's case was allocated to a social worker on 25 September. On 28 September, the allocated social worker called Doris, but received no reply.

3. 33 Police records state that on 2 October 2020, they were called to an incident whereby Doris had made threats against a female friend during an argument about where she could charge her mobile phone. Records show Chris then made a threat to 'stick a plastic bag over [Doris's friend's] head' and throttle her. This was reported to Police on the 8 October. This event was linked to an incident where Doris's 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).

3. 34 A further Police record for 2 October states that officers attended Doris's home following 'concerns regarding Chris' when Doris's friend called the Police. Doris and Chris were spoken to separately by officers, and Doris advised she was happy to have Chris living with her 'for the time being' and she 'appeared happy and did not disclose any concerns for her living situation'. She added that Chris was on the 'Orbit list' for a new house. Police advised Chris to 'chase this up' as it was 'important that he respects Doris and looks to move out soon'. Additional, and considerable, records linked to this incident state that Doris was given safeguarding advice after Police visited her home and found her safe and well. The Police record goes on to state that Doris had 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 at this time that Chris was paying Doris £40 per week in rent. The Police record also 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 further 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 that 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. The record continues that Doris stated she had won £25,000 through 'Bakker Prizes' and she intended to give Chris £1,000 as help towards a deposit for a flat.[26] 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 those made previously by Doris). Police listed concerns for Doris regarding this attendance as 'vulnerable due to her age, generosity and naivety' and it was noted that Doris intended to give Chris her valuable piano once he had moved

[26] Note – The Author of this report checked the Bakker Prize website (https://en-gb.bakker.com/pages/prize-winners-2020-2021) to determine the validity of Doris's claim here. There was no evidence of Doris's win on the site.

out. The Adult Protection Investigation sent from Police to the MASH for Doris on 2 October stated:

> *Doris has identified that Chris drinks a lot of alcohol. Chris refers to himself as a functioning alcoholic. Doris has also witnessed Chris become aggressive, abusive and intimidating to other people but states that this has not happened towards her. However, previous reports conflict with this and state that she has been subjected to this behaviour. This is not an ideal set up due to Chris's previous [offending]. There are also concerns that Chris may have somewhat control or a strong influence on Doris's current circumstance. Although Doris seems to be speaking for herself it is unclear on what happens when they are there alone.*

3. 35 Probation records, also for 2 October 2020, state that 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.'

3. 36 The following day, 3 October, SCCE records show an email was received from MASH Police outlining concerns for a third time for Doris as reported to them by a third-party, who Police believed was Doris's daughter.[27] This email included the statement 'it is unknown if she [Doris] has consented for information to be shared with adult social services.' Additional notes linked to this email stated a 'Police referral attached to LAS[28] 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'. These notes were 'sent to the allocated team' by Police.

3. 37 In response to the above Police email, the allocated social worker replied, via email, on 5 October. In this email, the social worker advised Doris had been spoken to and 'she retains mental capacity' and did not 'express any concerns in relation to potential financial abuse'. The email concluded that 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. Notes attached to this record state the social worker consulted a SAPC on this new contact and the previous decision not to consider a Mental Capacity Assessment (MCA) or Section 42 Safeguarding Assessment were appropriate as 'eligibility felt not to be met.' An email was sent from the East Locality Team to the Police MASH on 5 October advising that Doris's case would be closed to the social worker and re-allocated to East Older People / Physical Disability Reviews South. Feedback from ASC states that it is unclear whether the social worker intended for the case to be reviewed at a later date. However, records show that this review task was picked up but closed on 16 November by a locality AP. There is no record to clarify why this happened.

3. 38 Police records for 3 November 2020 show Doris called Police as bailiffs were at her door with a Court 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

[27] This was actually Doris's friend.
[28] The LAS database is the Social Services case management system.

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.'

3. 39 On 12 November, Chris appeared at Great Yarmouth Magistrates' Court for the offences of:

21/12/2019 Assault by beating - assaulted a woman by beating her
36CJ1111920
26/01/2020 Assault by beating of an emergency worker - PC
26/1/2020 Resist PC
26/01/2020 Use threatening / abusive words / behaviour likely to cause harassment, alarm or distress
36CJ1357720
31/03/2020 Contravene requirement as to restriction of movement during emergency period - Coronavirus
08/04/2020 Contravene requirement as to restriction of movement during emergency period - Coronavirus
08/04/2020 Contravene requirement as to restriction of movement during emergency period - Coronavirus
08/04/2020 Act as a pedlar without a pedlars certificate
Proceedings to consider a criminal behaviour order
36CJ1579020
01/06/2020 Use threatening / abusive / insulting words / behaviour to cause harassment / alarm / distress against a male
27/05/2020 Criminal damage to property valued under £5000 - A pillar to the value of £250 belonging to Market Gates Shopping Centre
01/06/2020 Individual fail to comply with a community protection notice
1/6/2020 Use threatening / abusive / insulting words / behaviour to cause harassment / alarm / distress
36CJ1596620
17/05/2020 Individual fail to comply with a community protection notice
36CJ1689520
16/06/2020 Use threatening / abusive / insulting words / behaviour to cause harassment / alarm / distress to a woman
16/6/2020 Use threatening / abusive / insulting words / behaviour to cause harassment / alarm / distress to another woman
16/6/20 Use threatening / abusive / insulting words / behaviour to cause harassment / alarm / distress
36CJ1307620
15/03/2020 Common assault - assaulted a woman by beating
Breach of Community Order.

At this hearing, 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.'

3. 40 On 16 November, an East OP/PD record states Doris's case was allocated to East AP (Duty Team) 'but appears to have been 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.'

3. 41 Ambulance Service records for 4 December 2020 show Doris called them as Chris had fallen in her home. Chris was drunk at this time, and he admitted he was

drinking 6 litres of cider a day. Although Chris initially refused treatment, he followed the ambulance crew out of Doris's home and asked to go to hospital as he was feeling unwell. On attendance at JPUH, Chris's notes state that he had suffered a seizure 'likely due to alcohol withdrawal'. Further notes from JPUH show Chris self-discharged 'against medical advice'. Chris attended JPUH again on 20 December for a 'Doppler' ultrasound test. However, he refused to wear a face covering and discharged himself.

3. 42 Police were called by Doris 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. Chris 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).[29]

3. 43 Chris contacted PALS[30] at JPUH on 26 January regarding a cancelled clinic appointment. He was told some clinics had been cancelled or amended due to Covid restrictions, and he would be contacted again with a new appointment. Chris's revised hospital appointment for a blood test had been cancelled, as he had refused to wear a face covering and had become 'verbally abusive and confrontational in his manner towards staff.'

3. 44 On 3 February, Doris's daughter, Laura, again contacted an AP at SCCE. The information passed to SCCE by Laura on this date is shown here verbatim from the record:

> ** Laura calling as has some concerns about her mum*
> ** She has made us aware before and has been told we would not be concerned as she has no care needs, but she does not agree with this*
> ** Doris lives with a man called Chris who is 40 and who is a drug addict*
> ** Laura is concerned he is controlling her and Doris has become a different person*
> ** Doris has got into a lot of debt and her granddaughter helped her get back on track and set up new accounts etc*
> ** Doris has now asked for her accounts back which has concerned them as she has said Chris is spending a lot of money on alcohol*
> ** Doris has said she wants Chris to move out and for Laura to move in*
> ** Doris has said she doesn't feel safe but has begged Laura not to tell anyone*
> ** She was very upset today Chris was smashing things last night and she said she would call the Police- he physically picked her up and put her in her room*
> ** Laura would like to know if there is anything we can do - please can someone call back to discuss*
> ** Laura is very concerned something bad will happen.*

[29] Chris's GP has no record of this appointment.

[30] PALS stands for Patient Advice and Liaison Service**.** It is a confidential service offering advice, support, and information on health-related matters when using the NHS. PALS provides a point of contact for patients to resolve concerns or problems, and information about the NHS complaints procedure.

As a consequence of this call, a case consultation between the SCCE AP and a Safeguarding Adults Practice Consultant was held to determine next steps. The action recorded was for the AP to 'check GP ref capacity / care needs' and to speak with Laura and then Doris to gain a better understanding of her capacity and needs. An email from the AP to the Team Leader, also dated 3 February, reflects the conversation between the AP and Laura:

> *I spoke to Doris's daughter again. She still does not want me to contact her mum as she says she thinks the conversations would go the same as last time, we would end up doing nothing and that would place her mum more at risk as she would stop telling her things. Daughter works in some kind of role in safeguarding herself. She has been reading about a case in a social work journal which she said is very similar to this, and that in that case it was viewed that family members telling the worker that they believe the person has care and support needs was (?should have been) enough, and she is telling me her mum has. She said 'you're not going to capture this in a single conversation' with her mum and said someone needs to physically see her and they would pick up on things from seeing her in person, they would not get over the phone. Daughter also said a GP might not know her capacity as they have limited contact, but she has seen her mum regularly over time, so has been able to see how she has changed. Daughter said it is reasonable to assume she has care and support needs, if not so much physical, then in terms of being able to protect herself and her finances. Daughter thinks I should be contacting the GP and suggested I should contact the police to gather information from them about what their views were when they had visited.*

A further record for the same date shows Laura had told the AP that she had visited Doris earlier in the week to pick up some sunflower seeds Doris had bought for her in Norwich (where she had travelled via a bus with Chris). The AP recorded that Laura had told her Doris was mouthing something unknown when she got to the door, and 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.'

3. 45 The SCCE AP called Doris's GP the following day (11 February) and left a message for the GP to call back. By 12 February, the AP had not heard back from the GP and so submitted an online form to the surgery outlining the safeguarding concerns raised by Laura and asking if the GP had any concerns regarding Doris's care needs, potential cognitive impairments, capacity or impaired capacity. This submission included detail regarding SCCE decisions taken in October not to progress the case on the grounds of no finding of capacity issues and no social care needs, however her daughter had disputed both these points, and the 'referral has been complicated' by [Doris's] daughter's reluctance for us to contact Doris at this stage, and also by Doris appearing independent.' The statement regarding Laura's reluctance here is reflected below:

> *Laura feels we could not adequately assess her mum's needs over the telephone.*
> *Doris begged her not to tell anyone and she is not aware of this referral.*
> *Laura is not able to move in. She thinks her mum wants her to in order that Chris would move out.*
> *Doris commonly tells Chris he needs to move out, but this becomes a recurring refrain rather than a plan and Laura feels she is not able to enforce it without support.*
> *Laura feels she needs alternatives to be given.*

She is concerned if it continues, her mum could be severely hurt or potentially die as Chris could 'go further' and grows in confidence when he gets away with more.
Police have frequently been involved but unable to take action to make him leave and warn Doris against him, but she chose to let him remain there each time. She owns her property.
Laura worried that if I were to contact her mum, but then 'do nothing' this could place her in more danger as it could lead to her stopping telling Laura things and reduce Laura's ability to support and act as a deterrent.
Laura suggested could we contact the GP and have the GP call Doris in for a health check, then the GP could assess her capacity re finances and her relationship with Chris?

3. 46 On 16 February 2021, Doris's GP responded to the AP, via the 'surgery website' and stated they (the GP) had spoken with Doris that day by telephone, and she 'has capacity'. The GP update went on to advise that Doris was due to attend the surgery for 'routine bloods' (no date given); that 'her partner' was not registered at the same surgery; and the GP had no further information. 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 as though the GPs statement was with respect to Doris's mental capacity to make decisions regarding taking her medication. The email stated the GP went on to advise the AP 'he did not mention Chris… he felt this would be too intrusive' and that it was a 'difficult situation, but... [the GP] thinks that the daughter may overstate things. He [the GP] has not visited [Doris] at home, but when he has spoken to her over the phone, he has not had concerns about any care needs.'

3. 47 JPUH received a further complaint from Chris, by letter (no date), on 22 February. An acknowledgement was sent on 24 February, with an action to send a combined response to Chris on 24 May.

3. 48 On 26 February 2021, the SCCE AP again emailed the SAPC (importance level: High), with an update on the case. In this email, the AP stated she had spoken with Doris's daughter (the 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 Chris which was in Doris's possession. From this 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. It is unclear how Doris came across this charge sheet. The email goes on to explain that Laura had stated her 'preference' would be for the case to be closed down, if a Section 42 enquiry would not be raised as a consequence of her contact with SCCE. The email suggests, but is not clear, that Laura at this point felt her mother would be hostile to any SCCE involvement (This point is clarified in a note in the submitted chronology, which states that 'daughter [Laura] expressing no point contacting [Doris] as she will decline support'). A further SCCE case consultation took place on 26 February between the Safeguarding Adults Practice Consultant and the AP. The action

arising from this meeting was 'to call [Doris] anyway with the approach that we are following up concerns raised last year.'

3. 49 On 3 March, Chris was seen by an outreach worker from Herring House 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.

3. 50 There was a further email from the AP to the Safeguarding Adults Practice Consultant on 5 March 2021 in which the AP advised she had spoken with Doris and 'she was quite happy living with Chris', 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.'

3. 51 On 6 March 2021, the GP received a notification from East of England Ambulance service 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, aside from the notification being filed.

3. 52 On 7 March 2021, the Police received a call from the Ambulance Service regarding 'concern that a domestic' was taking place at Doris's home. The ambulance had been called by Doris who could not wake Chris. When he did wake up, 'they' [the ambulance call handlers] heard Chris start shouting in the background. This record goes on to state that 'they [Doris and Chris] are not in a relationship together and this was not a domestic'. Paramedics attended this incident and were 'happy' that both Doris and Chris were well. The Police record states 'the noise that ambulance heard was the normal behaviour' of Chris and that Police had spoken with him and Doris and confirmed she had not been assaulted. A further Police record attached to this incident states Doris 'also gives Chris money, but unknown how much and how regular this is.' There were no further actions arising from this incident.

3. 53 Ambulance Service records state that the above incident was made known to them on 6 March at 12:59 when Doris called in about Chris. The record goes on to show:

> *999 call Uncategorised (patient shouting at the caller)*
> *Caller (friend of the patient) woke patient, who is homeless, who then shouted at the female. The female screamed and the phone went dead.*
> *CAD notes: call handler believes patient has attacked caller then line cleared.*
> *Speaking with the female who stated- he is asleep and when I wake him up he is abusive, took the phone and slammed it down. Is shouting and saying 'leave me alone, will you all P*** off, it's madness'. The caller advised the patient is an alcoholic and needs help. Police were called, Query a domestic it is noted in the CAD notes that the caller is screaming, the patient is shouting and swearing.*
> *Patient states he needs an ambulance as he needs detoxing.*

Police requested and on route to the address.
Crew advised dispatch that they were unable, after 30 mins, to find the patient. Ongoing domestic between drunk tenant and landlord. Some concerns around landlady's vulnerability- Police in contact with social services.

On attendance, the ambulance crew recorded the Police were dealing with the incident and Doris 'sounds helpless and unable to move the houseguest [Chris]' due to her age. A GP support referral for Doris was made by the ambulance crew at this time. On the same day (7 March), Chris called Police to report he had been assaulted by an unknown male at a local ATM and the male had 'stood on his head'. Police recorded No Further Action for this incident, due to 'evidential difficulties.'

3. 54 Records from Herring House for 9 March show that Chris had 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 Chris said he needed to sort his methadone as it was 'messing him up'.

3. 55 On 10 March 2021, the SCCE AP recorded a further case consultation with the SAPC as a consequence of their discussion with Doris on 5 March. The outcome of this discussion was to close Doris's case and advise her daughter, Laura, as there were no 'Safeguarding Adults issues indicated.' Also on 10 March, 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].

3. 56 Also on 10 March, Herring House records show that Chris was discussed at a Housing First meeting, where a potential Criminal Behaviour Order (CBO)[31] was flagged with regards to his anti-social behaviour on the local high street. This CBO had first been considered by Magistrates on 8 April 2020 but had been adjourned until 12 March 2021. Probation records show that Chris finally appeared before Magistrates on 30 April in relation to this CBO.

3. 57 On 11 March 2021, Ambulance Service records show that they were called in relation to an incident with Chris. The records state:

999 call for convulsions (Phone went dead- crashing and banging heard) from a third-party caller who was not on scene.
Patient was on phone to his mother, playing the piano for her. Patient fell off chair and mother called ambulance as the patient was not responding.
Patient states he has consumed 1.5 litres of gin, normal daily consumption.
Patient states seizures have started recently and have not been investigated as he does not have a GP. Patient is under the special allocation scheme.
Patient wants to be taken to A&E for a detox and states he will fake a seizure if he is not transported. Crew contacted A&E and were advised that a detox programme must be arranged via GP.

A GP Mental Health Support Referral was made for Chris at this time.

[31] See: https://www.cps.gov.uk/legal-guidance/criminal-behaviour-orders

3. 58 Probation records for 12 March show that Chris attended Great Yarmouth Magistrates' Court for the offence of 'breach of community order'. This case was adjourned until 27 April to 'tie in with other matters.' Also on 12 March, Ambulance Service records show that Doris called for an ambulance as she had fallen and was unable to get up. Chris initially refused to help Doris up from the floor, but then stated that he 'was able to help her up as he usually does', so the call was cancelled by Doris.

3. 59 Herring House records for 17 March show that Chris had emailed them requesting an appointment regarding accommodation questions and benefit advice.

3. 60 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. The record states 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'. Herring House records show that a formal safeguarding concern was raised by them with ASC on 8 April 2021.

3. 61 On 24 March, Chris visited the Herring House Centre, and gave staff an assured tenancy agreement that 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) 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 at 14:30, but he failed to attend.

3. 62 Two days later, on Friday 26 March 2021, ASC records show that a ASSD Mental Health East social worker received an email from a Herring Housing Trust worker requesting an update on Doris's safeguarding referral (safeguarding referral shown on other ASC records and Herring House records as a referral contact on Thursday 8 April. NB: 2 to 5 April 2021 was Easter Bank Holiday). The record goes on to state Chris's 'tenancy agreement [with Doris] was discussed' and a further appointment with him was scheduled for 31 March. The Herring Housing Trust worker stated she had attempted to contact Doris on 'a number of occasions' but had received no reply. The full content of the email from Herring Housing Trust to the social worker is as follows:

> *Just wondering if you managed to look into what happened with Doris's Safeguarding Referral after the Housing First meeting on Tuesday 23rd March?*
> *Chris accessed his appointment at The Herring Centre as arranged yesterday (25/03/21). He brought along a copy of an Assured Tenancy and wished to explore changing his benefits over from ESA to UC and to put in a claim for Housing Benefit.*
> *Staff advised Chris that he would require a Lodgers Tenancy Agreement.*
> *Chris stated that he will draw one up and fax this to staff to check.*

Chris stated that Doris lives on the ground floor and he lives on the first floor however, the Piano room is his which is located on the same floor as Doris.
Staff made a phone call to Doris as discussed and planned at Housing First while Chris was with other staff members however, there was no reply despite several attempts being made.
Staff and Chris have made a further appointment for next Thursday 31st March at 14.30hrs.
Chris later faxed over his new Lodgers Tenancy Agreement and staff have concerns regarding the wording e.g. describing the privileges of being allowed to have pets, the smoking of cigars with H&S taken into consideration and repairing any damage caused by the OWNER??????
Chris stated that he had studied Law in the past so he knows what he is doing.
I'm happy to scan over his rough copy to you. Also, the signatures are questionable.

On the same day, 26 March, records from Change Grow Live (CGL) show that Chris had 'entered service' and an assessment appointment had been offered to him. There is no further information in this record to indicate whether Chris had self-referred.

3. 63 Records for 1 April 2021 show the Approved Mental Health Professional at ASSD MH East replied to the Herring Housing Trust Pathway Worker's email. This email stated 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. On the same day, 1 April, records from JPUH show that Chris had called them, enquiring about a follow-up appointment. During this call he became abusive causing the practitioner to end the call.

3. 64 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.

3. 65 A 'safeguarding contact' was recorded by an Assistant Practitioner (AP) at SCCE on 8 April 2021. This contact was in the form of an email from Herring Housing Trust which stated:

The reason I am contacting you today is because a client that has approached us for help: Chris is living with a very vulnerable 80+ year old women, I do not know her myself however her daughter has contacted you before regarding her safety and their relationship. You are unable to contact Doris via phone call so please can someone visit the property to make sure she is safe and well. you have received reports about her before however the report was closed because she said she was fine on the phone but it has come to our attention that she has disclosed she does not want Chris in her house and that she is scared of him, you may be calling her with him in the house and she is therefore restricted to the information she can give you. I am asking for someone to look at this case again and attend the property to make sure she is okay because Chris is trying to create a

lodgers agreement so he can claim housing cost to live there. Chris has stated that her daughter does not like him but he does not know why but i am aware Doris's daughter has contacted you in the past raising concerns. Chris attended a meeting with us and when he was with us another colleague tried to call Doris to see if she was okay however no answer and again this raised concerns for us. Doris is an elderly lady who currently has Chris living under her roof. Chris suffers from Mental health issues and he takes drugs.

The record states 'case allocated SCCE', but it is unclear whether this refers to a new case being opened for SCCE, or whether this refers to previous engagements with Doris. It is noted that Herring House have no record of this email being sent.

3. 66 The following day, 9 April, JPUH records show Chris attended A & E with an infected burn to his leg. He self-discharged from hospital before his treatment was completed.

3. 67 Change Grow Live records for 12 April show Chris did not attend his scheduled appointment with them for this date. Also on 12 April, a complaints letter from Chris was received at JPUH, but this letter had no specific questions and did not raise any queries. Consequently, it was logged and filed. The following day, 13 April, JPUH received a further complaint from Chris (dated 9 April) with a Freedom of Information request (not detailed). The record states that a 'combined response' was sent to him on 24 May.

3. 68 Herring House records for 14 April 2021, record concerns for Doris were raised by them to all professionals in a Housing First meeting. Staff present noted that that when previous concerns were investigated, Doris had responded that she felt safe in Chris's presence, but that such investigations had been undertaken when Chris was with Doris. Staff at the meeting were concerned that this may mean that Doris wasn't able to express herself freely, and it was decided that when Chris was next at The Herring House Centre, staff would take the opportunity to call Doris and check on her when she was alone to ascertain if she was safe. This call was made by Herring House staff, but there was no answer from Doris.

3. 69 On 15 April, a record from the SCCE AP states that the AP was called by the referrer from Herring Housing Trust during which the referrer was advised that care and support concerns regarding Doris had previously been addressed and the case had been closed. During this conversation, the Herring Housing Trust worker expressed concerns regarding 'Chris asking Doris for a tenancy agreement, generally taking advantage.' This record further shows that a discussion 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 SCCE AP called Doris to discuss her care and health needs the same day, 14 April 2021. Records state 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 spoke with 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 telephone, by the AP the following day. Herring House records for 15 April show that ASC called Herring

House to advise that that 'Social Services are not going to do anything, as there was nothing wrong with her capacity so Doris is just making unwise choices.'

3. 70 On 18 April 2021, Police records show Doris and Chris 'have been arguing which is normal for them.' The record goes on to state that Chris had 'misplaced his Methadone and has self-prescribed with gin. The female party also drinks alcohol. Male party is due to see medical staff at the home address in the morning'. Police did attend Doris's address on this date and an Adult Protection Investigation (API) was recorded for both Doris and Chris at medium risk. No further action was taken by Police at this time.

3. 71 On 22 April, Doris was seen by a locum GP for a painful shoulder. There was no evidence of trauma to the area; a diagnosis of a 'frozen shoulder was made' and Doris was referred to physiotherapy. There was no indication of enquiry about domestic abuse as there was no marker on the record to indicate a history of domestic abuse.

3. 72 Chris attended a telephone appointment (due to Covid) with Change Grow Live on 27 April relating to an assessment of his needs. A note attached to this record states:

> *Client became abusive to staff during assessment and staff had to end the call due to inappropriate behaviour, discussed as a risk and identified that he should be seen for future appointments by 2 staff. during the assessment a female in the background began to talk and client became verbally abusive towards her. He was informed that his conduct was not acceptable and that the appointment may have to be re scheduled.*

There were no further actions recorded by Change Grow Live regarding this incident. Also 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.

3. 73 On 28 April Chris made two telephone calls to the Chief Executive Officer (CEO) at JPUH which were taken by the CEO's personal assistant. In these calls, Chris was enquiring about results from a recent PCR test. The action arising from this call was for PALS to follow up and determine where this PCR test had been taken. PALS records for 29 April and 30 April show three unanswered calls to Chris. Also on 28 April, Change Grow Live 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 action arising from this call was for the Change Grow Live worker to call Chris the following week.

3. 74 Probation records show Chris appeared at Great Yarmouth Magistrates' Court the same day (30 April) as per the call to Doris from Change Grow Live for a 'breach of Community Order and various Criminal offences.' The outcome of this appearance was:

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

3. 75 On 5 May 2021, Chris failed to attend his scheduled telephone appointment with Change Grow Live. The following day, 6 May, he was spoken to, and a further alcohol assessment was arranged with him for 19 May. On 7 May, Change Grow Live received a letter from Chris to their Chief Executive 'requesting his notes and information about the board of trustees.' A director of the service called Chris the same day and was advised that Chris couldn't remember sending the letter. Chris further advised 'he was going to be made homeless in the next 3 days.' The record goes on to state 'not all facts were known at this time, and there were possible safeguarding concerns.' A note attached to this record states that '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.' Also on 5 May, PALS records from JPUH state they had tried to call Chris regarding his PCR test results. The record explains PALS were unable to contact Chris at this time, and so his case was closed to them. A further record (from JPUH) for 5 May shows a complaint letter (dated 28 April) had been received from Chris, and this was responded to on 24 May.

3. 76 On 11 May 2021, Change Grow Live's locality manager and team leader undertook a home visit to Chris as he had failed to respond to telephone calls. Chris was found alone at Doris's home and told the manager and team leader that Doris had 'gone away for a few days.' The record states Chris also told them 'they had disagreements…but this was in the realms of normal relationships.' After this visit, the Change Grow Live record shows a discussion was held with Chris's worker and Chris was to be asked if he would consent to Change Grow Live contacting Doris.

3. 77 The following day, 12 May, Change Grow Live recorded a contact with 'health outreach special allocations GP service' who advised them 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[32] and Sustanon[33] every 3 weeks (to be self-administered). The heath outreach worker also advised Chris 'had a history of injecting Zomorph and deliberate self- harm using injecting needles to damage his arms' but Chris had reported 'no illicit opiate use or injecting for some time.'[34]

[32] Pregabalin is used to treat epilepsy and anxiety. It is also taken to treat nerve pain. NHS (www.nhs.uk)

[33] Sustanon is used in the treatment of male hypogonadism. It increases the testosterone levels in adult men and helps improve various health problems including impotence, infertility, low sex drive, tiredness, and depression. Sustanon is given by a doctor or a nurse administered by deep intramuscular injection every 3 weeks. It should not be self-administered at home. However, Chris did not see a nurse or doctor in person. It may be that the syringes seen by the Police on one of their visits were from the self-administration of this medication.

[34] Chris's GP has advised that he was taking the following medication:
- morphine pain relief (Zomorph 60mg modified release twice a day) -dispensed daily
-medicine for male hormone deficiency (Sustanon) – dispensed weekly
- antidepressant (Citalopram)- dispensed weekly
- medicine for nerve pain (Pregabalin 100mg twice a day)- dispensed weekly.
And that his diagnoses were:

3. 78 On 14 May 2021, JPUH received a further letter of complaint from Chris. The action arising from this letter was for JPUH to issue a combined response on 24 May to tie in with previous complaints from Chris. Records from JPUH further show a meeting between the CEO and a clinical doctor took place with regards to Chris's complaints, and between 18 and 26 May, the JPUH doctor contacted Chris's GP, (though we have no further records of these contacts).

3. 79 Police were called by Doris on 19 May and reported that Chris would not leave her address. Police heard 'a lot of arguing in the background, between a female and male.' Their records state events were 'really kicking off.' On attendance, Police found there was a 'verbal argument occurring between Chris and a woman called XXX [Doris's friend] …Doris sounds the victim in all of this. Doris's friend is erupting at what Chris is doing.' Police determined that the argument between Chris and Doris's friend was 'over some pictures on social media,' though there are no details as to the content of these pictures in the Police record. No further action was taken by Police at this time.

3. 80 On 22 May, Doris attended the A & E department at the James Paget University Hospital by ambulance with an abrasion to her knee which, she stated, occurred after getting trapped in a train door whilst on the way to friend's funeral on 16 May. Doris was x-rayed to exclude any potential fracture. The record states Doris had called an ambulance on 16th May, but she did not wait as she had a funeral to attend. Doris was discharged with a walking frame and provided with transport to take her home. Ambulance Service records from 22 May state that:

> *Patient 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. Patient states that friend stays awake all night and plays loud music during the evening. Patient 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. Patient states that the friend is drunk every day and they have to provide money each day in order to assist the friend with alcohol. Patient states that they feel scared of asking the friend to leave in case they kick off again which they have done previously, and Patient 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.*

An Adult Social Care referral was made for Doris by the Ambulance Service as a result of this call out. Also on 24 May 2021, the social work team at the James Paget University Hospital (JPUH) received an EE(A)1 contact form from the Ambulance Service following their contact with Doris. The referral stated:

> *Doris had a lodger who moved in a few years back, initially to stay 2 days a week. They have now become a full-time lodger at the address. The lodger is alcohol dependant and very aggressive in his mannerisms when he is drinking. To the extent that Doris feels unsafe & has to lock herself in*

Paranoid Schizophrenia
Opioid drug dependence
Chronic alcoholism
Borderline personality disorder 2017
Possible psychopathy presentation (17.06.2019)
Hypogonadism.

her room when this happens. The lodger will play loud music throughout the evening & night, meaning Doris is having broken sleep. Due to the cost of the alcohol, Doris is now giving him money to pay for it. If she doesn't give him the money, she is scared he is going to walk into her room. The lodger also knows the pin numbers for her cards. Doris would like assistance with evicting him, but she is scared of doing it on her own.

The action arising from this referral was for the JPUH social work team to 'follow up.'

3. 81 Following receipt of this referral, and also on 24 May, the JPUH social work team called Doris at home to discuss her leg injury. The record includes Doris 'felt safe as her lodger was in another room'. The record states:

Doris explained that her lodger, Chris, was only supposed to be staying with her short term, but had been with her now a long time, she just wants to help him get back on his feet after being homeless. She explained that he was a substance and alcohol user and was dependent on these but was also supportive to her and they were good friends. Doris said that if Chris runs out of money, he will ask her for some and has on two occasions over the past 2 years, has become aggressive towards her, I asked if this was physical aggression and she said 'yes, twice now, when I tried to call my daughter or neighbours when he was asking for money and I refused, he took the phone from me.' I asked Doris if she would like our support in getting Chris removed from her home, she said she would like some support in getting him housed if he had a flat he could go to, otherwise no and she did not feel at risk from him at this present time - she suggested that they got on well. I suggested that as he had been aggressive towards her in the past, that the Police could attend and have him removed if that was her wish, she said 'absolutely not, I would not have him on the streets again.' I asked Doris what she would do if Chris were to become aggressive again and she was worried or frightened of his behaviour, she said she would call the Police, her daughter or neighbours, I suggested that Chris may take the phone from her again, then what could she do, she said well I am meeting my daughter today and she is going to get me a phone where we can talk over a video- a mobile- and she will show me how to use it. Doris said she would have her mobile phone then and could use that to get help if she needed to and Chris did not need to know she had it.

The social worker went on to record they discussed a referral for Doris to the Assistive Technology Service for a fall alarm, and Doris had agreed to this referral. This 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 from the JPUH social worker to the Assistive Technology Service was made the same day and Doris was placed on a 6-8 week waiting list. A letter of confirmation was sent to Doris. Also on 24 May 2021, the JPUH CEO wrote to Chris regarding his prior complaints on 22 February, 13 April and 5 May.

3. 82 Police records for 26 May, show they were called by Doris during the early hours of the morning (02:35hrs) reporting 'Chris was shouting and swearing at her' and Doris 'was very upset and did not want Chris at the address'. Police attended Doris's home at 03:10hrs the same day 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.

3. 83 On 27 May 2021, Change Grow Live called Chris to confirm his appointment with a Recovery Coordinator for 2 June. This was followed up with a further telephone call reminder on 1 June when Chris said, 'he would try and attend.'

3. 84 Doris called the SCCE Assistant Practitioner (AP) on 1 June to request an assessment for Chris. Doris advised Chris was a 'substance and alcohol abuser.' The notes state that Doris was 'quite upset on the phone, said she couldn't take it anymore.' The AP recorded that Chris was 'outside her property whilst we were on the phone. I did not get the impression that Police involvement was immediately necessary.' Doris asked the AP if someone could call her back. The AP called Doris back the same day and spoke to her privately. The record of this call states Doris had said:

She 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.

3. 85 Also on 1 June 2021, Police records show that Doris called Police at 21:13hrs as Chris was 'here again' and had called her a 'c***' and other 'horrible names.' Doris advised 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. The record states Doris was 'happy for him [Chris] to remain there tonight' but she would be seeking support from CAB to help him move out. Doris further advised Chris hadn't assaulted her but he had called her a 'c***' when 'she

made him jump' by closing the curtains. No offences or complaints were recorded by Police.

3. 86 The following day, 2 June, Chris attended his nurse alcohol assessment with Change Grow Live. He presented as 'unkempt and in soiled clothing'. Chris told the nurse he did not want any information about him recorded, and he was drinking 750ml of gin a day, starting when he woke up. The record states Chris was 'hostile from the outset' and began using offensive language before walking out of his appointment. 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'. During this call, Doris advised the Client Recovery worker that when Chris was 'paid the following week', Police had advised her to give him 2 weeks' notice to leave the property. Doris further reported 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.'

3. 87 On 4 June 2021, Doris changed her GP Practice.

3. 88 Change Grow Live wrote to Chris on 7 June 2021 to 'encourage engagement and remind him of his conduct during appointments.' This generated a voicemail from Chris on 12 June 'with abusive content.'

3. 89 On 14 June, Change Grow Live received a telephone call from the special allocations GP service requesting a referral into Change Grow Live for Chris. The special allocations GP service was advised that Chris was already open to the service. The following day, 15 June, Chris called Change Grow Live regarding his GP prescriptions. Chris is recorded as being 'abusive' to staff and stated he no longer wanted to work with the service. Two days later a Change Grow Live worker called Doris on 16 June to 'see how she was.' Chris answered this call and was 'rude' to the worker who concluded the call as a result. The same day, Chris called PALS at JPUH 'demanding to be put through to CEO.' This call was 'terminated' by Chris, and PALS contacted the Executive PA to inform them of the incident.

3. 90 On 18 June, a Change Grow Live worker again called Doris to establish if Chris was still at her address. Doris said she had written a letter to Chris telling him he must leave her home 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 her new GP practice and was seen by a clinical practitioner. Records for this visit state:

> *Seen with generalised knees and arm pains after getting trapped in train door and falling from train whilst travelling to friend's funeral. Since accident has lost confidence with walking with her frame and worries how she is going to be in the future due to her age and how she will cope on her own. Noted her son passed away in December 2020 and was her carer. Reported she is "accommodating" Chris, a 41-year-old homeless man who lives with her temporarily. She said he 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. Examination performed for external injuries. Follow up telephone call arranged.*

As a result of this disclosure, the GP discussed the case with the surgery safeguarding lead and arranged a follow-up call with Doris.

3. 91 Records from JPUH show that on 21 June they received a further letter of complaint from Chris (dated 17 June). The action arising from this letter was for checks to be undertaken with the doctor who had been tasked with contacting Chris's GP as a result of previous complaints. As there were no 'specific questions or queries' contained in Chris's letter, it was 'logged and acknowledged' by JPUH staff.

3. 92 Cambridge City Council Customer Service Centre records for 22 June 2021 show Chris contacted them to enquire about properties in Cambridge. During this contact, he advised that 'he was living in a lady's shed at XXX, Great Yarmouth. He said that he was being threatened by local residents who believe that he has 'done something. He says they regularly attack him. He wants to flee to Cambridge. He says that the lady's family are scared of him and tell her to ask him to leave but he doesn't know why.' Three days later (25 June), the Housing Advice Service at Cambridge City Council called Chris and their record for this activity states:

> *Chris advises that he is living with Doris. He claims that she will be evicting him that day with the help of the Police. He says he doesn't know why but blames her family. He claims that he has been allowed to stay in Doris's shed in return for carrying out jobs arounds the house. He says that he has been effectively homeless for 3 years. He claims to have been abused and attacked by local people for reasons which are unclear. He claims it's because he's different from others. He says that he has reported these incidents to the Police most recently on 18th June.*

The action arising from this call with Chris was for the Housing Advisor to contact Norfolk Police and Doris to verify Chris's circumstances. The same day (25 June), the Housing Advisor emailed Norfolk Police and called Doris at home. At the time of the call, Police were in attendance. The record is as follows:

> *Doris passed handset to PC XX.*[35] *PC XX confirmed that Chris is living in Doris's property, not in shed. Doris no longer wants him there. Family have expressed concerns about financial abuse, coercion and possible physical abuse. Police say that they would like Chris removed from property but can't be arrested for anything at that point in time. Also an acknowledgement of his housing rights as Doris's lodger. Housing Advisor advises that Doris would just need to issue a reasonable notice to bring the arrangement with Chris to an end. Police advise that a safeguarding referral has been completed. Advise too that he is not at risk from others in the Great Yarmouth area.*

A further contact with Chris on 1 July 2021 was made by the Housing Advisor, who told Chris that his circumstances were 'not as he described' and that he was not living in a shed and was not at risk. Chris responded to this by saying the 'Police were lying.' Chris was offered a further telephone appointment but hung up the call. Further attempts were made to contact him by phone on 2 and 3 September before the case was closed on 9 September.

3. 93 Doris's daughter, Laura, again called SCCE on 24 June 2021 to report Doris had told her that Chris had broken a lock on Doris's bedroom door. The recorded contact between Laura and the SCCE AP is given here:

[35] Name redacted by DHR author.

- 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.

The record goes on to state that Laura felt as though she was 'getting nowhere' with concerns regarding her mother and requested a call back from SCCE. However, when the Chair and Author met with Laura in March 2024, Laura contested the notes shown above stating that she did not find 'it difficult to explain' what her mother was experiencing, and that she was very clear with the SCCE what the situation was, and what her concerns about Doris were.

3. 94 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 said she 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. Also on 25 June, a Change Grow Live worker tried to call Doris, but Chris answered the phone and advised that Doris had gone out for a meal with friends.

3. 95 Police did attend Doris's home on 25 June as Doris wanted Chris removed from her home. Police records show Chris produced a copy of a 'Tenant's Agreement' and on reading this, attending officers concluded it was 'more of a civil matter.' The safeguarding note attached to this record states while officers were present, Doris received a call from Cambridge Council enquiring after Chris's wellbeing. According to the Police record, Chris had contacted them 'stating he was at risk of immediate violence,' but Police had advised the Council this was not the case. Police also 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 period required. In the notes, Police record they uploaded a copy of the 'Tenant's Agreement' to their Athena database, they spoke with Laura following this incident and advised her to contact Great Yarmouth Borough Council to ascertain the minimum notice period 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. When the Chair and Author met with Laura in March 2024, she challenged this record by explaining that she was present throughout this Police attendance. Laura said she remembered that Doris found the episode 'amusing' as she was struggling to understand what was going on at the time. Laura further advised that her son, Jack, had undertaken some online research to determine which type of tenancy agreement Chris had drawn up, and how long the notice period was for this. The result of Jack's online search was that the tenancy agreement was an 'excluded tenancy agreement' with a notice period of 1 week. Laura provided a copy of an email she had sent to Police at this time. It read:

Hello

Re: Mrs Doris XXX, (address redacted by the Author)

Following our conversation last week I did leave a message regarding the notice period my mum needs to give Chris. I thought it may be best to email as I am not always easy to get hold of via phone.

From the information I have been given the notice period is one week, as the rent is paid weekly (if it was monthly it would be one month etc...).

My mum is really keen for him to move out so would appreciate it if you could go and witness her giving him this notice period.

My mum often goes out in the day but is always in after 5. Is it possible to go after 5 as soon as you are able next week.

Thank you so much for your help with this matter.

Kind regards

Laura

No response was received from the Police at this time, and Laura feels as though this was a missed opportunity for Police to take action against Chris.

3. 96 On 28 June 2021, Laura called SCCE to advise that Police had attended her mother's address on 25 June, but as Chris had 'got her mother to sign a contract saying he was a tenant' he could stay there for 3 years. Laura advised that Police had stated 'it was a civil matter' but they were due to attend Doris's home the same day to witness Doris giving Chris formal notice to leave. The same day, the SCCE AP contacted the Assistive Technology Service to follow up on Doris's referral as there were 'possible safeguarding issues.' The SCCE AP was advised that Assistive Technology would undertake a home visit with Doris the next week, and Laura and Doris were aware of this. However, the Assistive Technology record for this date states they contacted Laura to arrange a telephone assessment with Doris for 30 June. Also on 28 June, the clinical practitioner at the GP surgery rang Doris back as a result of the disclosure 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 action arising from this call was for the practitioner to discuss the case with the GP with a plan to refer to the Social Prescriber Service 'for social issues and frailty.' A further record, from Change Grow Live for 28 June shows their worker called Doris, who advised she had called Police as Chris was refusing to leave. Doris further stated Police had advised 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 Change Grow Live worker she was unsure if this would happen 'that particular week or the following week.'

3. 97 The following day, 29 June 2021, Change Grow Live 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.' As a result of this, Chris became abusive, stated he did not want a service and then walked out. Chris was discharged the same day, with a note made explaining 'Police were aware of Doris's situation.'

3. 98 On 30 June, the Assistive Technology Team called Doris and Laura to undertake an Integrated Housing Adaptation Team 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. The action arising from this assessment was for a community alarm to be installed at Doris's home.

3. 99 The SCCE AP records show that on 2 July, they received a safeguarding contact from a Community Health Social Prescriber (CHSP), who advised:

> **Doris allowed a homeless man, named Chris, to stay with her last year*
> **They signed a civil agreement to state that he could stay at the property for three years.*
> **The agreement also stated that the man would pay her £80/week, which has not happened.*
> **She says that the man has been physically aggressive towards herself on two separate occasions.*
> **On another occasion he smashed a glass and tore a radiator from the wall which left her feeling very intimidated.*
> **She also reports that Chris drinks.*
> **[A CHSP worker] spoke to the man today; he was initially pleasant but later thought that [the worker] was a doctor, at which point he became very aggressive.*
> *Does the person have any care and support needs (appearance of need)?*
> **n/a*

*Has actual harm (physical, emotional, financial, etc.) to the person occurred? *Possible financial *Possible physical.*
*Has Police/GP/medical input been required? *The Police have been informed but cannot act further because of the civil agreement.*
**The referral originally came to [a CHSP worker] from Doris's GP.*
*Does the person have capacity in relation to the incident? *Unknown.*
*Is the person aware the referral has been made? *Yes.*

The AP responded to this contact by calling the CHSP 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 their Endocrine Clinic as JPUH had been unable to contact him. GP records show that a social prescribing health coach received an email from Police which stated a police constable confirmed 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.'

3. 100 On 6 July 2021, the SCCE AP discussed the referral from CHSP with their SCCE 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 record goes on to say 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 consequence, this, and the CHSP contact were closed the same day.

3. 101 The next day, 7 July, 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, but the record also states Chris 'continues to deny Covid measures.' 'Concerns' were recorded by staff that an inpatient admission would be 'challenging' due to Chris's non-compliance with Covid measures.

3. 102 The SCCE AP received a telephone call from a social prescriber (CHSP) in mid-July to advise they had spoken with Laura and Chris was still at Doris's home and 'Doris has not asked that he move.' The AP advised CHSP 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'. Following the above meeting, Laura provided a copy of an email from her to the social prescriber to the Chair and Author. This correspondence, and the social prescriber's response is given here in full:

Hi XXX (the social prescriber's name has been redacted by the Author)

Its easier for me to email than text.

First of all, thank you for taking an interest and a concern in this situation.

I spoke to my mum this morning. She seems okay, she has been in a friendship with a woman with mental health problems and veers between helping her to having big arguments and this seems to be taking a lot of her attention. I'm wondering if this is why she has forgotten.

Did you want me to remind my mum about the appointments?

I also meant to summarize my more general worries about the current situation and why I think that this is making my mum vulnerable.

Over the past couple of years my mum has become increasingly uninhibited. The background to this is both the grief at death of two sons (which has escalated the problems), and a fall in which she hit her head.

Forming relationships with various people seems to be a pattern that has arisen because of the above. All the people she is forming relationships with, have experienced some level of difficulty/abuse/mental health problems/substance abuse

Prior to this my mum was very inhibited, very unsocial and didn't mix easily. Now she is the complete opposite. The positive is that she is less miserable, the negative is that it has made her more vulnerable to abuse from people who have needs themselves and may therefore take advantage of her.

This is because she is easily taken in and doesn't seem to be able to assess when something is wrong or untruthful just believing everything that she is told.

She also doesn't seem to retain an emotional memory (not sure how else to put this). Often she can remember facts just not how she felt, again this is different to how she was previously. Previously her anger was deep and lasting, now she just brushes everything off. Again, there is obviously a positive but the negative is that Chris can effectively do what he likes to her house, including breaking things she really values, saying appalling things, physically frightening her, and before long it is as if it hasn't happened. She remembers the facts of what he has done, but not how she felt.

My mum is still actively saying she wants Chris out but nothing seems to be changing. I imagine what will happen next there will be another escalation of Chris's drinking related behaviours which will lead my mum to involving the police again. At least this time we will know where we stand with the tenancy.

I feel myself in a very difficult situation. I am pleased my mum seems happy (she does) but I am worried that she is being taken advantage of. I try to keep an eye on the situation and my mum tells me, I think, most things.

Thanks Laura

The social prescriber's response to this email was:

Hi Laura,

Thank you for your email and informing of your mother's history. And your perception of everything that is going on. I understand this must all be very stressful and I hope that you have a good support around you.

I emailed my police contact last week following our conversation, but I am yet to hear anything.

I spoke with XXX[36] from adult safe guarding this week, who arranged the pendent alarm and fire alarms for Doris. They stated that Doris told her that she doesn't want Chris removed. I did challenge this and explained that Doris said to me on three separate phone calls that she does want Chris removed and that he has physically restrained her in the past. I believe XX is now going to discuss this with their peers.

Unfortunately, I don't think there is anything more that I can do within my powers. But, please do let me know if there are any other referrals you think would be suitable and I'll discuss these with Doris. And any new information I receive I'll pass onto you if appropriate.

Kind regards.

3. 103 Again, In July, JPUH received a telephone complaint from Chris. The record shows Chris was 'muddled' and 'verbally abusive' and 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.

3. 104 Also, in July 2021, Police records show they 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 and had been heavily drinking 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.*

Police records go on to explain that Chris had been removed from the address and threatened with a breach of the peace, but 'due to uncertainty of offence occurring' and Doris not confirming 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.

[36] Name and sex / gender of the ASC worker redacted by the Author.

4. Overview

4.1 This overview section provides a brief summary of information known to the agencies involved in this Review who had contact with Doris and Chris.

4.2 Norfolk Police had a significant history of contact with Chris; from 1 June 2020 and the date he was arrested for Doris's murder, Chris was arrested 8 times during the period of review, initially due to vulnerabilities arising from his homelessness, and latterly with regards to concerns raised about him by Doris, her family, and other agencies. 121 crime investigations are recorded on Athena since 2015 in which Chris is a victim or offender, of these Chris was arrested and held in custody 33 times. Norfolk Police also had frequent contact with Doris, with regards to her experiences of abuse from Chris. Concerns relating to Doris were escalated to ASC by Police.

4.3 Norfolk ASC opened a total of 7 safeguarding concerns for Doris, 3 from the Police 1 from Herring House, 1 from the Ambulance Service to the Hospital Social Work Team, and 1 from the Social Prescriber. They also held significant information relating to Doris and Chris, either through direct contact, or via Doris's family or other agencies. Whilst Chris was never considered to be an 'adult at risk' in his own right by ASC, Doris was considered to be vulnerable, but for reasons set out elsewhere in this review, her needs were never appropriately assessed and the risks to her from Chris were never fully explored.

4.4 Doris's GPs were aware of concerns about Doris's capacity (having been contacted by ASC to determine her capacity) and were also aware of safety concerns regarding her relationship with Chris (following information received from Doris). Information held by Doris's GP was not escalated appropriately via established safeguarding routes.

4.5 The Probation service was aware of Chris's offending history and of the risks he posed to others. At no point was the Probation service aware that Chris had taken residency in Doris's home. Risk assessments were either not undertaken or were only partially completed by the Probation service.

4.6 GYBC were aware of Chris's needs with regards to accommodation, and escalated concerns they had regarding Chris living with Doris via a local multi-agency forum.

4.7 Chris never fully engaged with Change Grow Live, but they did identify safeguarding concerns relating to Doris, and these were escalated via a further multi-agency forum.

4.8 The Ambulance Service held no information relating to Chris but did escalate safeguarding concerns they had relating to Doris to the social work team at JPUH.

4.9 Doris's daughter, granddaughter and grandson all had concerns about Chris's behaviour towards Doris. Laura and Chloe raised concerns directly with the Police and / or ASC.[37] Although their concerns were considered by agencies, no appropriately robust action was taken as a consequence.

[37] Note: During a meeting with Laura in March 2024, Laura told the Chair and Author that a further concern for Doris had been raised with ASC by a plumber who had visited her home. However, there is no note of this concern in the ASC records submitted to this review.

Additional information from Doris's family

4.10 In addition to the agency information presented above and the input from Doris's family presented elsewhere in this review, following the conclusion of Chris's criminal trial Laura provided additional information to the Chair via email in June 2023, regarding the nature of Doris and Chris's relationship. On receipt, the Chair checked to determine whether Laura and her daughter, Chloe, consented to the information being presented in this review. Full consent was given, and the correspondence is given in full here:

> *It was never just a suspicion that Chris and my mum had had a sexual relationship. My mum first disclosed to Chloe that they were in a sexual relationship and then she told me, when I questioned this, of their intention to marry so she could leave him the house (in the early days of the abuse). I remember being shocked at this and saying to my mum how can she be sure he doesn't just want the house. And the warning bells that had already started were suddenly getting much louder.*
>
> *He [Chris] moved a double bed from upstairs into her bedroom and whilst I now (only very recently) realise that neither my mum nor the abuser confirmed this when questioned (after I reported it to the Police) he can be heard twice on Police video cam referencing the intimacy of their relationship.*
>
> *First, when I was with the officers in the garden looking for my mum the day after (or of) her murder. He was explaining how clothing got into the pond and said that my mum had fallen into the pond and he had got her out (this was true, my mum told me). He said to me that I would know this, as she tells me everything now they are no longer sharing a room. This was a reference to the fact that he used to listen to her phone calls when they were living in my mum's downstairs 'flat' together.*
>
> *And another time he can be heard referencing them having a lover's tiff.*
>
> *I heard both in the court and I remember especially because Chloe was so scared each time the press would pick up on it and it would be made public.*
>
> *The prosecution left this out of their case because my mum had never confirmed this. And it was argued to me on more than one occasion that it was not necessary to convict him and might be something the tabloids pick up on. For me it didn't matter that it was not used in court. But it is true, and I happen to like the truth. And now it does matter if the Police are arguing that this falls outside the scope of domestic abuse.*
>
> *I believe he groomed her into thinking he was her lover. My mum said he started to talk to her about pornography and would walk about her house naked touching himself. I think she felt flattered, but I also think she was very confused and for me this was further evidence of my mum's capacity issues. I cannot overstate how uncomfortable any topic involving sex used to be to my mum. So, to hear her talking about this openly and giggling was strange and very concerning.*
>
> *I wonder if the Police did not see this because of the age difference? Had they been age matched would they have just assumed that this was a partner relationship?*

I did not know until after my mum's murder that the Police investigated my concerns about the sexual relationship and that my mum and Chris had denied it. No-one told me. They never spoke to me further and they never questioned Chloe. Why was this? We were the ones that it was disclosed to so why did not they not want to know more. If they thought it untrue did they not want to know why we had lied to the Police? If they thought it true but unprovable, then this would mean they knew the situation was one of domestic violence. Which was it? Or did they just drop it and not think about it again?

Was it more convenient to present this as a lodger and landlady because the truth is actually very unpleasant and very uncomfortable. Was that discomfort a barrier to their seeing this as a domestic abuse situation?

And this might really matter to understanding his crime and preventing future occurrences, because I do believe that this fed his sense of entitlement to my mum's property and money in part because he had been relatively successful in convincing her they were in some kind of relationship. And I believe that that sense of entitlement grew and grew, and his anger, when he felt it all slipping away, increased. And isn't that a pattern in domestic violence?

Additional information from Chris

4.11 The Chair and Author of this review met with Chris in prison in September 2023 to gain his perceptions of services offered to him prior to the homicide and if anything could have been done differently by agencies in contact with him, and Doris.

4.12 Chris stated he came from a supportive and loving home and since being in prison he had realised that "mine is a very unhappy case… I didn't realise how lucky I was. I can't fall back on any excuse." He went on to tell us that he had first engaged with mental health services at the age of 15 and had difficulties fitting in due to "the hypocrisy and expectations of society and the complexities of adolescence". He wanted psychotherapy 'on the couch' as he had seen on television, but he did not receive any such intervention. Teenage angst or depression was evident, and he was also sexually active from a young age.

4.13 Chris explained that he needed help and guidance to navigate society, that he was creative and enjoyed music, but he needed help developing his sexuality. When asked for clarification Chris was unable, or unwilling, to define or expand on what he meant by this. He felt the pressure came from within. He told us he was placed on antidepressants (Seroxat[38] and Lustral[39]) but did not take the medication.

4.14 Chris said he was diagnosed with a personality disorder and his problems worsened throughout his teenage years. He stated he had a problem with the doctor patient

[38] Seroxat is a brand name for Paroxetine. Paroxetine is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It is often used to treat depression, and sometimes obsessive-compulsive disorder (OCD), panic attacks, anxiety or post-traumatic stress disorder (PTSD). See: https://www.nhs.uk/medicines/paroxetine/about-paroxetine/

[39] Lustral is a brand name for Sertraline. Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). It is often used to treat depression, and also sometimes panic attacks, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). See: https://www.nhs.uk/medicines/sertraline/about-sertraline/

confidentiality arrangement, and it was difficult for him to raise some issues in case they were escalated. By the age of 15 he had had problems for seven or eight years of repressive thoughts and was repressing elements of his sexuality which left him lonely. Chris went on to state that "he was a hard man to help" because of the barriers he put up. He would drink heavily and would self-medicate with alcohol. He felt he needed early identification and intervention when substance misuse and poor mental health were presenting. He related an incident where he had overdosed on yoghurt heavily laced with cannabis and had to attend Accident and Emergency, but he received no ongoing support following this incident.

4.15 Chris also reported that he was sexually abused by an older boy while at his first school and this had upset his development. Chris had disclosed the sexual assault to his GP but was put on antidepressants and was not referred into another service. The school were unaware of the abuse.

4.16 Chris also recalled a rape allegation against him which occurred sometime around 2001. He described the allegations as spurious, but he was arrested and lost his job as a consequence. He reported that he tried to throw himself off a balcony as a result of this incident. Shortly thereafter he stopped drinking and started running along the beach. He found the support from the Early Intervention Team positive - it was both social and practical support; the focus was holistic, and support was there if needed. However, Chris described an incident where he threw a piano stool through the front door which he then barricaded with boxes, and he was eating only butter. He thought it was the Early Intervention Team worker who had made a referral which resulted in him being Sectioned for schizoaffective disorder at this time. Chris told us he thought God and the government were involved in that Sectioning.[40] After release from his Section, Chris reported he got in with a bad group who started stealing his property and it was around this time he started using heroin. He said he was introduced to this drug through the group.

4.17 Between 2004 and 2010 Chris reported he was supported by a CPN under the Norfolk and Suffolk Mental Health Trust. He said he wanted a psychosexual service at the local hospital in Lowestoft (he had seen a poster on a notice board) but did not receive a referral. He also requested a referral to a specialist service in London which was initially agreed but then withdrawn by a senior partner in his GP practice. Chris told us he was living a modest and artistic life at this time, writing and recording music, and he was active in playing music for the church choir.

4.18 By 2006 Chris admitted he was using a significant amount of cannabis and said it was the "most insidious drug available." In 2008 he had a serious breakdown and was diagnosed with episodic psychotic depression and paranoia after a significant relationship broke down wherein his partner terminated her pregnancy. He was referred to an Early Intervention Team, but he maintained he did not receive any medication.

4.19 Chris went on to tell us he had been "involuntarily celibate" for most of his life and had only had two physical relationships. He reported travelling to the Philippines around 2006 to combat the issue of involuntary celibacy by "securing physical intimacy." However, he would not expand further on what the trip to the Philippines entailed when asked by the Chair and Author.

4.20 In 2012 he was evicted and became homeless. Chris alleged he was assaulted by his CPN at Victoria House in Lowestoft and was then discharged from that service

[40] GP records submitted to this review show that Chris was 'Sectioned' in 2009.

following the allegation of theft of a cheque which he maintained he did not receive. He explained he wanted to reengage with the service, but it would have taken 12 months, and he did not want to wait that long. He also explained that because he was homeless, he did not receive mail and he had no mobile phone on which to be contacted. He described himself as not a well man at that time and for years he was taking 400 milligrams of Diamorphine[41] sometimes intravenously and was addicted to Zopiclone[42] sleeping pills which he bought on the street. Chris reported that his GP had told him he could not take him off Diamorphine due to the impact of withdrawal. Chris felt at this time he needed to be institutionalised; he said "they should have locked me up" to get clean.

4.21 Chris explained he was deregistered from his GP due to his behaviour and referred to a separate GP surgery which had a security guard, but that service was cut, and consultations were then via a call centre. He said he saw a GP once in two years after the deregistration. He recalled he would frequently send faxes and letters to services which were construed as malicious and dealt with as anti-social behaviour by these services, but no agency picked up his mental health needs from these communications.

4.22 Chris reported that he had been assessed by ATOS[43] at some point in 2013 or 2014 and that his disability living allowance benefits had been withdrawn. This also caused accommodation problems and he felt this was a significant barrier in terms of secure accommodation and moving area. Chris also thought the reduction in his benefits allowance was a major driver for future issues. He said the capability assessments by ATOS was not holistic and did not include anything confirming or relating to his poor mental health.

4.23 Chris described his relationship with Doris as one of friendship and landlady. He said they were really close. The relationship was volatile on occasion but there were a lot of laughs, and it was fun. He said when he was living with Doris, he was not using anything apart from alcohol. Chris did not recall any agency trying to support him while living with Doris. He was never referred to Adult Social Care, indeed he did not appear to know what that service provided.

4.24 During the period he was living in Doris's home, Chris told us he had tried to move to Cambridge because he was well known in his local area for bad behaviour and had been accused and assaulted for being a paedophile. He felt in danger in the area, and he thought that Cambridge would be a good place to live for musicians and those interested in the arts.

4.25 When asked if there was any sexual element to the relationship between Doris and himself, Chris seemed surprised and said that Doris got into his bed a few times until he asked her to stop, and this had upset him. He also said that Doris sometimes had really bad mood swings, and she developed problems in one hand where she had difficulty gripping things.

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[41] Diamorphine is a strong, effective painkiller, known as an Opioid. It is most frequently used to reduce the pain associated with childbirth. See: https://www.nhstayside.scot.nhs.uk/OurServicesA-Z/MaternityServices/PROD_341727/index.htm#:~:text=Diamorphine%20is%20a%20strong%2C%20effective%20painkiller%2C%20known%20as%20an%20Opioid.

[42] Zopiclone is a type of sleeping pill that can be taken for short-term treatment of severe insomnia. See: https://www.nhs.uk/medicines/zopiclone/about-zopiclone/

[43] Atos was a company which assessed whether benefit claimants in Britain were fit to work up to the end of its contract in 2014.

5. Analysis

5.1 This analysis will be informed by the review's Terms of Reference and will examine how agencies responded to the needs of Doris. The analysis will identify any gaps in practice relating to Doris and Chris, and also highlight good practice, where appropriate. The analysis here is informed by panel discussions, IMR content, and relevant academic / practice-based literature.

1. The review will identify and examine in detail agency contact with the victim and the perpetrator between June 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.

5.2 All agencies complied with the above request in full and the chronology in this review has been informed by relevant records.

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?

Police:

5.3 Norfolk Constabulary considered Doris to be an 'adult at risk' and regularly submitted Adult Protection Investigation notifications (APIs) to the local MASH for further review and support.[44]

5.4 Given that Chris was recognised as alcohol dependent and to have mental health issues by Police, consideration, as per College of Policing guidance[45] should have been given to assess him as an 'adult at risk' in his own right.

Adult Social Care:

5.5 Adult Social Care (ASC) completed a preventative assessment by an Occupational Therapist for Doris in 2019. Which identified her health and mobility vulnerabilities. The assessment showed that she had 'some needs' but these were being met though 'adaptations to her environment'. This pre-dated Chris moving into her home and there were no concerns that Doris was an 'adult at risk' at this time.

[44] An API is a risk assessment carried out for vulnerable adults on scene which is then placed in a triage queue for secondary safeguarding in the MASH.
[45] See: https://www.college.police.uk/app/major-investigation-and-public-protection/adults-risk

5.6 A safeguarding concern from the Police received by ASC on 6 August 2020, following information from her daughter, Laura. The Police referral included the information that Doris had told her daughter that Chris would frequently become drunk and would then act strangely such as pretending he is a dog, walk around naked, touch himself over his clothing in front of her, and on numerous occasions they had engaged in sexual intercourse with one another. It was noted by ASC that Doris had been living independently with 'some support with bills and finances' and had been seen one month previously by her GP, who 'deemed her to be lucid and not confused'. During contact with ASC at this time, Doris did not raise any concerns about Chris. The referral did not include Chris's previous Police history, but despite the concerning information within the referral Doris was not considered an 'adult at risk' and further enquiries made.

5.7 A second concern was received from Police by ASC on 6 September 2020 after Doris's granddaughter, Chloe, raised concerns that Doris had asked Chris to leave, but he had returned to her home. The concern was discussed with a Safeguarding Adults Practice Consultant (SAPC1). As the chronology (shows 3.19 – 3.26) there were frequent phone calls between ASC, Doris and Laura her daughter regarding this referral. Calls with Laura raised a number of concerns posed by Chris to her mother and examples of his behaviour given in addition to his alcohol and drug use. Also, he had "embedded himself and taken over the house", something he had done before with others. The concerns of the Police and Laura about Chris were shared with Doris, but she had replied "I don't think he'd ever hurt me." The caller asked whether she still wanted help to get Chris to leave as she had said last time they spoke, and Doris said no (she did not remember the previous call), she would talk to him and tell him that her family don't like him and he needs to go; she felt Chris needed support with his mental health. There appears to be no recognition of the risks such a conversion with Chris might have for Doris, nor is there recording that this discussion took place with Doris. The caller then asked Doris about her ability to complete her daily tasks and she confirmed she is totally independent; she said she did not require support. The ASC notes show Laura reported a nurse from Doris's GP surgery had contacted Doris and had no concerns about her capacity. This was followed up rightly by ASC on 9 September with the GP practice who confirmed 'there was no diagnosis of cognitive impairment that could affect her decision-making or mental capacity'.

5.8 On 14 September 2020, Laura again contacted ASC to advise she was concerned about a shift in her mother's character, and she was concerned that Doris had early signs of dementia. Laura also reported that Chris had visited Great Yarmouth Borough Council (GYBC) to discuss housing options.

5.9 Salient records from the calls include Doris confirming she did not require support and did not want to take action against Chris. She wanted him to have accommodation and GYBC had been contacted for this. The notes show Doris 'did not seem happy about him living there' and that 'she had learned her lesson and would never do it again'. In another call Doris called ASC to say that Chris had returned to her home 'drunk' the previous night, and she would 'like some help'.

5.10 ASC records for 22 September show that Doris 'was believed to be independent with daily tasks and does not appear to have care and support needs and she had not reported abuse'. At this time, ASC believed Doris to have mental capacity as she appeared able to seek assistance from the Police or GYBC if needed. Therefore, there was not enough evidence for a safeguarding enquiry. Doris was not considered to be an 'adult at risk'. This information was passed to Laura, who went on to highlight a number of areas where she felt her mother did needed

support. Laura advised Doris had been relieved when the Police had removed Chris from her home but had since forgotten that she had been afraid of him and had enabled him to return as a consequence. At this point, the SAPC decided to transfer the case to Eastern locality's community care team for a face-to-face Care Act assessment and a Mental Capacity Act assessment at Doris's home. The rationale was to establish whether Doris had needs under the Care Act (regardless of whether the local authority was meeting those needs) and whether she had mental capacity with regard to the alleged perpetrator residing at her property.

5.11 The assigned social worker (SW1) called Doris to establish contact on 28 September 2020. During this call Chris took the phone from Doris and 'spoke in an angry and agitated way'. Subsequently, the social worker ended the call to Doris and instead called Laura. Laura was asked to assess Doris's mental capacity and to contact the Police if 'things get complicated'. What is meant by this instruction (if things get complicated) is not clear. The fact that Chris took the phone and was angry and agitated to the extent that SW1 ended the call did not result in a consideration or assessment of risk towards Doris.

5.12 SW1 did not carry out the visit as requested by SAPC1. An interview was held with SW1 who said they did not read back far enough into Doris's record to recognise the risks to Doris and as such did not seem to appreciate the seriousness of the case. SW1 said as SCCE had been involved on a number of occasions, they made an assumption that the case was not complex. SW1 acknowledged that the phone call should have been followed up with a face-to-face visit, especially as Doris was unable to speak freely with Chris in the room. SW1 said they were concerned they were being intrusive. A discussion also took place with SW1 about how the visit was necessary and efforts should have been made to see Doris alone. Although Doris had been thought by the GP to have capacity (relating to contact between ASC and the GP on 16 February 2021), this should have been checked as she may still have been making unwise decisions and been at risk. SW1 relayed to SAPC2 that Doris had mental capacity and did not express any concerns about abuse, and she was managing all her care needs independently. SW1 did not seem to understand that Chris's behaviour evidenced serious concern for Doris. The Director of Operations for Eastern locality has since identified that it would have been beneficial for SW1 to have spoken to a manager before closing Doris's case. When the Chair and Author consulted with Laura in March 2024, Laura advised that she was told that ASC had visited Doris and she had been physically seen by them. Laura felt strongly that ASC did not respond to the escalation of risks that she communicated to them, and that as Chris's behaviours had 'evolved' and become more extreme over time, ASC should have responded to this pattern with visits to Doris.

5.13 Following the case closure, there were subsequent assumptions made by ASC that Doris had capacity and did not have care and support needs. These assumptions were informed by the belief that the case had initially been sent to the locality team therefore a face-to-face visit would have taken place. However, the almost routine focus on 'care and support needs' in assessments ignores the fact that Doris was, as the Care Act definition (b) states '*is experiencing, <u>or is at risk of</u>, 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.* Doris's small build and limited mobility, which was never considered, would have put her at significant risk from Chris who was both much taller and larger in stature.

5.14 The flaws in assessments and lack of face-to-face visits meant Doris was not defined by ASC as an 'adult at risk', but the IMR submitted to this review by ASC

finds that consideration should have been given to further assessment and raising a section 42 enquiry.

5.15 Since Doris's murder, the procedure for in person visits has been updated to say that if two or more safeguarding concerns are raised about the same person, a face-to-face visit must take place.

5.16 Given the concerns for Doris were raised by a number of different sources, this review would suggest the need to go further and recommend that such a level and number of safeguarding concerns should result in an inter-disciplinary meeting, similar to those which take place in the hospital or community health setting when a person attends their services over and above the normal level. More attention should have been paid to Chris's background and behaviour and the risk he posed, not just assessing Doris's care and support needs. Doris was owed a duty of care.

5.17 At no point did ASC consider Chris to be an 'adult at risk' in his own right, despite a local safeguarding policy[46] which clearly establishes that his vulnerabilities met the criteria for such a consideration. The Adult Social Care Panel member clarified Chris would not have been considered as an "adult at risk" under the Care Act safeguarding criteria as he was not experiencing/at risk of experiencing abuse or neglect. He could have potentially been considered as an adult with care and support needs.

GP Practice:

5.18 Doris's GP Partner spoke with her, via telephone, following receipt of the ASC concern on 16 February 2021. The GP Partner had been asked to provide a perspective on the likelihood of her care needs, as well as cognitive impairment or impaired capacity. The GP Partner notes show that Doris 'has capacity, can answer all questions, talked re. current events'. A full functional capacity assessment is not recorded at this time. However, on further discussion with the GP Partner, they have advised an assessment of capacity was completed in compliance with the Mental Capacity Act 2005. The GP Partner has further advised that they completed a dementia assessment with Doris. However, given the fact that this was a telephone assessment it would be difficult to distinguish between decisional and executive capacity and if there was any impact of coercion. It does not appear that Doris was invited into the surgery to be seen face-to-face and unaccompanied to explore this further. Government led Covid-19 restrictions are likely to have had an impact on the availability of face-to-face appointments at the surgery although the GP practice confirms that patients continued to be seen face-to-face if required at this time.

5.19 There are no submissions to this review that suggest Chris was considered as an 'adult at risk' by his GP.

5.20 Despite holding knowledge that Chris suffered from poor mental health, had previous admissions to a mental health facility, was misusing substances, and was frequently homeless, the Probation Service did not consider or undertake any referrals for Chris as an 'adult at risk' according to relevant national policy guidance.[47] The Probation Service IMR has identified this failure to make onward referrals for Chris as a missed opportunity.

[46] See: https://www.norfolksafeguardingadultsboard.info/protecting-adults/

[47] See: https://assets.publishing.service.gov.uk/media/5e7b2803e90e0706ee64a78e/Probation_HSNA_Guidance.pdf

East of England Ambulance Service NHS Trust:

5.21 The Ambulance Service (EEAST) first identified Doris as an 'adult at risk' on 6 March 2021 when they attended her home address in response to Chris being found unconscious. As Doris had withheld consent for an ASC referral, EEAST used a GP Support Referral to raise concerns that Chris was 'taking advantage of Doris's age and is forcibly remaining in the property against Doris's wishes.'

5.22 Concerns around Chris were escalated by EEAST on 11 March 2021 via a GP Support Referral (as he had withheld consent to an ASC referral) requesting an onward referral for a 'detox' programme. This referral was in response to Chris being found unresponsive after a fall from a piano stool.

5.23 EEAST again identified Doris as an 'adult at risk' and made an ASC referral for her on 22 May 2021 following a call-out to her home in response to Doris's knee injury. The referral noted that Chris was a lodger in Doris's home, was alcohol dependent, and 'very aggressive in his mannerisms' when he was drunk. The referral went on to state that Doris felt unsafe around Chris and had to lock herself in her room. Doris was paying for Chris's alcohol, and he had knowledge of her PIN numbers. Chris would also play loud music throughout the night, disrupting Doris's sleep. She was scared that he would walk into her room at night. The referral noted that Doris wanted support to evict Chris from her home.

James Paget University Hospital (JPUH):

5.24 The JPUH IMR has found no evidence that ED staff were made verbally aware of EEAST's concerns around Doris, or that she was asked about her wellbeing during her single visit to the hospital following the call-out described above (22 May).

Change Grow Live:

5.25 Change Grow Live (CGL) were unable to undertake a full assessment of Chris's needs as he did not fully engage with the service. Although Doris was spoken to in person and by phone by CGL, she advised them that she was 'okay' and 'in conversations with the Police about evicting Chris'. Subsequently, no safeguarding concerns were raised.

Great Yarmouth Borough Council:

5.26 The Great Yarmouth Borough Council (GYBC) IMR return shows that Chris had a number of contacts with the council prior to the temporal scope of this review, and although staff identified that he could be 'difficult and obstructive', he was felt to be able to manage his affairs and was not at risk from others. Following Doris's contact with GYBC on 7 November 2020, staff did have concerns about her safety and escalated these via a multi-agency collaboration meeting on 10 November. Concerns were raised again by GYBC on 20 April 2021 during a further multi-agency collaboration meeting after a Pathway Worker at the Herring House Trust had advised that safeguarding concerns relating to Doris were not 'being taken up by the appropriate authorities'. Police feedback to GYBC at this time was that no action could be taken against Chris and that Doris had capacity to determine whether, or not, Chris could live at her property.

5.27 GYBC had four additional contacts with Chris. Contacts on 25 March 2020 and 27 March 2020 were conducted via intercom due to Covid-19 restrictions. Due to the brevity of these contacts, there was insufficient time for staff to consider his potential status as an 'adult at risk'. During face-to-face interactions with Chris on 31 March and 14 May 2021, staff noted no concerns which would classify him as 'at risk'.

5.28 It is telling that Doris was not considered to be an 'adult at risk' by ASC, although other relevant agencies (such as Police and EEAST) and her family felt very much otherwise. Consideration should have been given by ASC to a further assessment and raising of a s42 enquiry into Doris's needs. Such an enquiry would have enabled ASC to:

- establish facts
- ascertain Doris's views and wishes (without Chris in the vicinity)
- assess the needs of Doris for protection, support, and redress and how they might be met
- protect from the abuse and neglect, in accordance with the wishes of Doris
- make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect
- enable Doris to achieve resolution and recovery.[48]

Subsequently, failures to assess Doris as an 'adult at risk' or via a s42 enquiry are considered to be significantly missed opportunities in this case.

5.29 Chris was not considered to be an 'adult at risk' in his own right by Norfolk Police, ASC, Probation services, or his GP, despite national and local policy and guidance to the contrary. EEAST did identify him as a potential 'adult at risk', but as Chris had withheld his consent for EEAST to make a referral to ASC, this referral was never made. As a substitute, Chris's needs were raised by EEAST via a GP Support Referral which at least shared their concerns within Health. Failures by agencies to consider Chris as an 'adult in need' constitute missed opportunities in this case.

5.30 More attention should have been paid to Chris's background known to agencies, plus his behaviour and the risk he posed. As a result of his aggressive and unpredictable behaviour professionals saw him in pairs, even the Police visited with double crews, and yet the risk he posed to a caring, petite, vulnerable elderly woman was ignored when Doris was an adult at risk and deserving of protection from Chris.

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

5.31 Concerns from Laura were raised on 2 occasions, and by Chloe once with Norfolk Police. Laura also continued to share examples of incidents or behaviours which caused her great concern for her mother during phone calls from and to Adult Social Care and other services. Both Laura and Chloe were concerned that Doris and Chris were in a 'domestic intimate relationship' and confirmed these concerns with Police on 6 August 2020 (Laura), 1 September 2020 (Chloe), and 2 October 2020 (Laura). However, Police records for 16 August 2020 also show that Laura was uncertain about the nature of Doris and Chris's relationship. When spoken to independently by Police, Doris and Chris denied they were in an intimate

[48] Paraphrased here from paragraph 14.94 of Care and Support Statutory Guidance (DHSC, 2018). See: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

relationship. Subsequently, Norfolk Police did not consider the relationship between Doris and Chris to be of an intimate nature, and so responses were not implemented according to local domestic abuse policies. However, as described above, Police did consider Doris to be an 'adult at risk' and submitted Adult Protection Investigation notifications (APIs) to the local MASH for further review and support. Following a meeting between Laura, the Chair and Author in March 2024, Laura provided her thoughts regarding Norfolk Police's response to the concerns she raised with them about her mother. Laura's correspondence is given here in full:

> *In the conversations I had with the police, I got the impression that they were exasperated that they kept telling my mum not to let him back in and yet she still did. The police officer attending knew my mum and said that they had told her not to let him back in (in the context of the tenancy agreement meaning they could no longer do this). I couldn't at the time and still struggle to understand why they didn't see what was happening. My mum was 83. Up until 2020 the police will have rarely if ever gone to her house. Yet all of a sudden they are being frequently called as an 83 year old struggles to manage the behaviours of a 39 yr old man who has moved into her house. During that visit at the end of June I explained to the police, in front of my mum, that she was struggling cognitively and had been for some time. I was very clear about this as I had been throughout this time. They maintained that as far as they're concerned she had capacity. I could perhaps understand if my mum had been known to the police all her life, and these kind of extreme social issues were 'normal' for her. But they clearly weren't. Rather than exasperation at my mum's failure to stick to her decision that she wanted him out when he was at times terrifying her, I really don't understand why they didn't see that my mum was simply not able to stick to that decision, because she was being so heavily manipulated and did not have the capacity to see this.*

5.32 Adult Social Care records show a Police safeguarding concern for Doris was received by the local MASH on 6 August 2020 following a call to them by Laura, who had expressed concerns about Chris's behaviour, the nature of the relationship between Doris and Chris, and fears that her mother may be suffering from the early stages of dementia. Doris was contacted via phone by an Assistant Practitioner (AP1) and advised that Chris needed support around substance misuse and accommodation. Doris's capacity and safety were considered by AP1, but no care or support needs were identified. Subsequently, Doris was supplied with the telephone number for GYBC and advised that Chris should contact his GP for support around substance misuse.

5.33 A second Police safeguarding concern was received by ASC via the MASH on 6 September 2020 following concerns raised once more by Laura that Chris was taking advantage of her mother and would leave the property only to return later. Doris was called by a different Assistant Practitioner (AP2) who confirmed that 'she could speak freely'. ASC notes show Doris advised AP2 that she enjoyed Chris's company, was not afraid of him, but wanted him to find somewhere else to live. Doris's frequent contact with Laura and Chloe were perceived to be protective factors. The action taken following Laura's concerns was AP2 contacted Doris's GP, who advised there was no diagnosis of cognitive impairment or a condition that could affected her mental capacity. Doris was called back by AP2 but could not remember their previous conversation. Doris initially said she did not need any support and she felt Chris would 'never hurt her', but she called back the following day to say that she would like Chris to leave her home. SAPC1 reported that Doris appeared to be independent with daily living tasks, and although it was felt she may have had some 'memory issues', it was believed she had capacity. Feedback was

provided to Laura, and an email was sent to Police advising of the outcome. Chris was contacted directly by ASC to establish if he needed further support at this time.

5.34 During the conversation between ASC and Laura on 22 September, Laura reiterated concerns about Doris's care and support needs and stated that Doris was afraid of Chris. Laura also disclosed she had heard Chris shouting at Doris while she and Doris were on the phone together. Laura added that Doris may be having difficulties with her 'contextual memory.' When ASC called Doris the same day, she advised that she could 'speak freely', although Chris was heard in the background to say that Doris did not have permission to speak about him. Doris informed ASC that she was not scared of Chris but wanted him to find a place of his own to live; she also told ASC she felt Laura was 'behaving unreasonably' towards Chris. Doris consented to a Care Act assessment, and following advice from SAPC1, the case was transferred to the Eastern Locality Team for a face-to-face Care Act assessment and a Mental Capacity Act assessment. The Eastern Locality social worker (SW1) did make a telephone call to Doris, but as previously described, did not visit face-to-face or undertake either assessment with her.

5.35 On 3 October 2020, the MASH received a third safeguarding concern from Laura, via the Police wherein Laura was concerned that Chris was financially abusing Doris, and Doris may have care and support needs. This concern was received whilst the case was still allocated to Eastern Locality. Police advised ASC they had spoken with Doris, and she had 'no concerns' about Chris. SW1 discussed the concern with SAPC2 and said Doris 'appeared to have no care and support needs' and had mental capacity with regards to Chris living with her. SW1 also said Doris had not 'expressed any concerns regarding financial abuse'. However, notes recorded on the ASC case management system (Liquid Logic Adult Social Care Data System, or LAS) at the time do not reflect any discussion around financial abuse with Doris. Nor do they contain any information relating to the fact that Chris had taken the phone from Doris resulting in SW1 terminating the call. When interviewed by the ASC IMR for this review, SAPC2 said that he was not made aware of any history relating to the case, nor did he check records on LAS for this information. Subsequently, the case was closed by SW1 and placed on the Eastern Locality holding list. The case was later closed completely by Assistant Practitioner 3 (AP3) at the request of SW1.

5.36 Laura again raised a concern that Doris was being controlled and financially exploited by Chris on 3 February 2021. Laura told Assistant Practitioner 4 (AP4) that Chris had become abusive towards Doris when she refused to give him money for alcohol, and he had begun to 'smash things then picked her [Doris] up and put her in her room'. Laura expressed further concerns around Doris's capacity, and she had psychological and social needs which, combined with her vulnerability, exposed her to risks from other people and 'to scams.' Laura also stated that Doris had been forgetting to take her pain medication for a knee injury. AP4 then contacted SAPC3 for a consultation and was directed to contact Doris's GP relating to her capacity. This GP contact resulted in ASC being informed that Doris had no diagnosed cognitive impairment, as determined during a phone call between the GP and Doris. ASC notes record Laura requested the concern be closed, as Laura felt Doris would decline support and had the right to make 'volatile decisions.' AP4 contacted Doris again by phone some two weeks later when Doris said she was happy living with Chris. She did not appear confused and was able to recall content from the previous conversation. Risks, safety, care needs and capacity were explored with her. AP4's notes also show that when Chris had entered the room from which Doris was speaking, Doris changed the subject to the possibility of having a downstairs shower fitted. AP4 could also hear Chris talking in the

background about a tenancy agreement. As a consequence of the call to Doris, SAPC3 advised that the case should be closed down. When interviewed for the ASC IMR for the review, SAPC3 stated that they had failed to 'pick up' on the allegations of Chris having picked Doris up and putting her in her room. They had also failed to read the case history on LAS and so did not identify accumulating risk to Doris.

5.37 Doris's GP received an electronic notification from a call handler at EEAST on 6 March indicating that Chris was intoxicated and taking advantage of Doris's age by forcibly remaining in her property. The call handler stated that 'the patient sounds helpless and unable to move the guest due to her age.' This was good practice by the ambulance crew. The GP surgery did not use professional curiosity to explore this notification with Doris and no further action was taken.

5.38 On 23 March 2021, Pathway Workers from Herring House Trust raised a safeguarding concern at a Housing First meeting, which was attended by SW3 (Eastern Locality MH Team). They identified concerns about Chris residing with Doris. SW3 reviewed Doris's records and advised, via email, that safeguarding issues had been investigated the previous month, with no further actions. The Pathway Workers raised further concerns relating to Chris's 'tenancy agreement' with Doris on 26 March and were advised to log a safeguarding concern via Norfolk County Council's 'front door'.

5.39 The Pathway Workers at Herring House Trust raised the concern on 8 April 2021. Chris had approached them for support, and staff had concerns he was living with a 'vulnerable person.' ASC records suggest that Laura had expressed fears to Herring House that Chris was trying to create a 'lodger's agreement' with Doris. However, Herring House have no record of any contact with Laura. AP5 discussed the case with SCCE PC1 who advised AP5 to contact Doris, but to close the case if there were 'still no care and support needs or capacity issues' on the basis that the safeguarding team had already reviewed the case twice. AP5 contacted Doris by phone and was told Doris was concerned 'her daughter keeps calling people about Chris because she and Chris wouldn't have their Covid-19 injections'. The ASC record shows in AP5's opinion Doris was managing her care needs and there 'was no reason to question what she [Doris] was saying'. However, it was not clear if Chris was present at the time of the call, as this was not checked by AP5. In any case, the feedback given to Herring House was that no further action would be taken. The ASC IMR states decision-making at this time seems to have been informed by prior decision-making.

5.40 A safeguarding concern for Doris's safety was raised by EEAST staff via the JPUH social work team on 22 May 2021 after an ambulance had took Doris to hospital following her fall / leg injury. This action by EEAST related to concerns that Chris had access to Doris's debit card PIN and the fact that Doris was giving Chris money to buy alcohol. The EEAST referral stated that Doris was afraid of what might happen if she withheld money from Chris. This was the second action by ambulance staff after they correctly identified risk to Doris from Chris. The JPUH social work team did not receive the referral until after Doris's discharge, so SW2 called Doris to follow up. Doris advised SW2 she could speak freely as Chris was in another room. Doris told SW2 that Chris had demanded money from her and on two occasions had become aggressive with her. Doris also said she would like support to have Chris re-homed. SW2 checked what Doris would do if Chris did become aggressive, and Doris replied that she would call her daughter via a mobile phone which Laura was buying for her. SW2's case notes record that Doris demonstrated 'decisional capacity', but her 'executive capacity' was not confirmed. SW2's action

was to make a referral for Doris to the Assistive Technology team for a falls alarm as a means to summon help in an emergency. However, SW2 did not read the LAS record to find out whether, or not, the home visit and assessments requested in September 2020 had actually taken place. Subsequently, Doris was advised to call Laura or the Police if she had further concerns about Chris's behaviour. There was no recognition that Chris's behaviours described by Doris potentially constituted crimes and a report made to the Police or Section 42 enquiries should be invoked.

5.41 Doris contacted ASC directly on 1 June 2021 to ask for help in removing Chris from her home. AP6 called her back and was advised that Chris was outside of the house at the time. Doris said she had signed an agreement with Chris whereby he could stay in her house for three years after her death, although a solicitor had told her [Doris] the agreement was not legally binding. Doris said the Police had visited her home but as Chris was 'never threatening or abusive when they are there' there was nothing the Police could do. Action taken was SW6 signposted Doris to Citizen's Advice Bureau for support with 'housing / tenancy' issues. Interviews with SW6, for this review, found they had not taken previous concerns or accumulated risk into account before undertaking this action. Since Doris's death, AP6 has been reminded that they must consult with managers where there is a 'concern about domestic abuse', and they have been asked to attend further safeguarding training. AP6 has also been reminded of the importance of using professional curiosity during engagements with service users.

5.42 Later, on 18 June 2021, Doris told a clinician at her medical practice that she was 'accommodating' Chris, who was an alcoholic. Doris said Chris had broken chairs in her home, and on one occasion had lifted her and threw her onto a chair. Doris said she had asked Chris to leave. During a follow-up call some two weeks later, Doris advised Chris was still living with her, the Police had visited, and she 'had her doors locked'. The clinician made a referral to the Social Prescriber Service for Doris for 'social issues and frailty', but no ASC safeguarding referral was made, or discussion held with Doris.

5.43 On 24 June 2021, Laura raised another safeguarding concern with ASC wherein she stated Doris had told her that Chris had broken the lock to her bedroom door. This was the only lockable room in the interior of Doris's home. Laura told ASC she thought Chris was coercively controlling Doris, Doris was fearful of Chris, and there had been previous examples of physical, financial, and emotional abuse perpetrated by Chris against Doris. Laura also told ASC that Doris's GP had found her memory to be 'fine', but Laura was concerned that Doris's emotional memory was such that she could not recall things that had happened between her and Chris. AP7 called Laura and was advised that Chris was due to leave Doris's home the same day. The following week, Laura called AP7 to report that Chris had not left Doris's home, as Police had advised that because of the 'signed contract' the issue was considered to be a civil one, and a solicitor was required. Police had clarified that Doris need only give Chris seven days' notice to leave, and they would visit the same day to witness this notice. AP7 advised Laura that the Assistive Technology Team were due to undertake a home visit with Doris the following week to discuss fitting an emergency alarm. A telephone-based appointment for 30 June was made with Laura, and following this assessment, it was confirmed that Doris would have a community alarm installed in her home.

5.44 On 2 July 2021, the Social Prescriber from Doris's GP surgery raised a safeguarding concern for Doris with ASC, at the request of her GP. The concerns related to 'two episodes of physical aggression, damage to property, and 'possible financial abuse', thus issues constituting abuse were clearly identified. AP7 attempted to call the

Social Prescriber, and messages were left to advise that AP7 was 'already dealing with the case'. AP7 then consulted with a manager (SCCE TM1) and was advised there was no safeguarding role as Doris had been referred to the Assistive Technology Team. This decision was taken on the basis that the safeguarding team had been consulted previously and determined that there was no role for them. The decision to take no further action was not informed by the new information from the Social Prescriber which clearly named abusive behaviours being experienced by Doris. This has since been 'discussed' with SCCE TM1.

5.45 Notes from Doris's GP practice relating to the above referral show the Social Prescriber received an email directly from Police stating that due to Doris and Chris's 'tenancy agreement' Police had no powers to remove Chris and Doris had been advised to seek legal advice. This decision also fails to recognise the risk posed to Doris by Chris's behaviour in addition to Chris's previous history known to the Police.

5.46 On 19 July, the Social Prescriber notified AP7 that Chris was still living with Doris. AP7 advised that Doris had recently been provided with equipment to 'call for support if needed'. AP7 did not discuss this new information with their manager. When interviewed for this review, SCCE TM1 recalled the case discussion with AP7. During this discussion, SCCE TM1 advised AP7 to check whether Doris had capacity. SCCE TM1 also felt that the proposed visit by the Assistive Technology Team constituted a protective factor for Doris. However, SCCE TM1 did not check historical records at this time and made the decision not to progress to safeguarding on limited information regarding Chris's refusal to leave Doris's home, Laura's constant concerns about Doris's capacity and decision making, and information from AP7 that the Eastern Locality Team had 'looked into' prior concerns already. SCCE TM1 noted that AP7 was mistaken in their understanding that the Assistive Technology Team would visit Doris in person, and further noted that AP7 did not pass any further update to them. SCCE TM1 had assumed that AP7's line manager had already given advice, so did not proactively follow these issues up. SCCE TM1 has since been reminded of the need to review LAS records when giving advice to other staff.

5.47 It should be noted that the mere fitting of an alarm does not constitute fool-proof protection. Chris could easily overpower Doris as evidence suggests i.e. picking her up and throwing her into a chair, and he could easily damage or disable the alarm. Thus, viewing this as a protective factor is overly optimistic in such cases. Safety planning demands more than one single action.

5.48 Due to Chris's poor engagement with Probation services, staff were unaware that he was living with Doris, or that Doris may have been at risk from him.

5.49 During discussions between Change Grow Live staff and Doris, at no time did Doris express any concerns about her personal safety, even when asked directly about this.

5.50 Doris did not disclose any concerns to GYBC about her personal safety.

5.51 The final concern for Doris's wellbeing was raised by a close neighbour on the evening of the final Police callout. The Police CAD note for this incident shows that Doris's neighbour had called Police to report that Doris had knocked on his door seeking help, as Chris was drunk and behaving aggressively toward her by 'throwing things around the kitchen'. On attendance, Doris will still with her neighbour and Chris was spoken to by the four officers responding to the call. The

CAD note states that officers found some pasta sauce on the floor of Doris's kitchen, and that this was the 'only thing that was out of place'. As Doris had sustained no injuries, and no offences were identified by the attending officers, Chris was advised to leave Doris's home and return 'tomorrow when he is not intoxicated'. After Chris had left the premises, and having noted that Doris's back-door lock was broken, officers attempted to secure the door by propping a chair up against it. Later the same evening, Police undertook a 'drive-by' of Doris's home and found nothing to be amiss.

5.52 With regards to the final Police attendance and subsequent welfare call made by Laura reporting her mother as missing, Laura made a formal complaint to the IOPC on 2 February 2022. In her statement to the IOPC, Laura 'expressed dissatisfaction' with the following Police activities (paraphrased here):

a) That Police did not prevent Chris from abusing Doris.
b) The Police did not use legal powers to prevent him from returning to the house.
c) That Police did not use legal powers to get him to leave the house at any time.
d) That the Police did not look for Doris the day Laura raised a concern after they said that they would.
e) That Police did not take her concerns regarding her mother being missing early enough.

5.53 The IOPC investigation was concluded, and their final report was published in January 2023. None of Laura's complaints were upheld by the IPOC at this time.

5.54 In addition to the evidence submitted to this review from relevant agencies that Doris was known to be at risk from Chris, Doris, Laura and Chloe themselves made frequent contact with relevant agencies to raise concerns and seek support in removing Chris from Doris's home. It is acknowledged that, at times, Doris made contradictory statements to agencies regarding the risks Chris posed to her, and also regarding her wishes for Chris to be housed elsewhere. However, the Review Panel feels these contradictions are understandable in light of two key factors. First, Doris was a victim of abuse and was being coercively controlled by Chris. Second, victims of abuse will often adapt their behaviour to appease their abuser to protect themselves from further abuse e.g. Doris changing the subject when Chris entered the room when she was on the phone to a social worker. Thirdly, we do not know whether Doris was or was not suffering from mental impairment in the period prior to her murder which could have impacted on her decision-making and short-term memory as no one fully accessed her in person. Her daughter Laura and her grandchildren who knew her best all reported changes in Doris's behaviour such that they sincerely believed she had some cognitive impairment which affected aspects of her ability to make safe decisions.

5.55 Research shows that victims of abuse may struggle with maintaining help-seeking behaviours due to an internal 'cost / benefit equation'. Felson, et al., (2002) found that this equation is most frequently informed by deliberations regarding:

- *Self-protection*
- *Fear of reprisal*
- *Perception of the abuse as 'trivial'*
- *Concerns around privacy*
- *The victim's desire to protect the offender*
- *Issues with Police 'leniency'.*

Further research, by Evans and Feder (2014) supports the notion of a victim's 'cost / benefit' analysis acting as a precursor to help-seeking. Their findings state:

> *Over three quarters of women experiencing DVA [domestic violence and abuse] disclose the abuse at some point, but disclosure may be limited and come after a long period using private strategies, such as placating or reframing their experiences, to cope within the abusive relationship… Women experience many barriers to accessing services, such as feelings of shame or denial, lack of trust in others or fear of repercussions such as the perpetrator finding out or family members seeking revenge.*

Whilst it can never be known for certain whether the inconsistencies in Doris's recollection of events and/or help-seeking behaviours resulted from her status as a victim of abuse, in this case the evidence presented to this review by agencies and Doris's family strongly suggests that she felt protective towards Chris, subsequently downplayed the risks Chris posed to her, and was concerned with protecting her privacy (from agencies, and from her family). Additionally, when Doris and her family sought support from agencies, usually to help remove Chris from her home, this support was not forthcoming even when Chris's behaviour was reported as explicitly abusive towards Doris. This may have been construed by Doris as 'leniency' towards Chris and may have constituted a further barrier to Doris's help-seeking.

5.56 The potential impacts of Chris's coercive and controlling behaviours towards Doris will be discussed in more detail under Term of Reference 5 (below).

4. What risk assessment tool or checklist did services in contact with the victim or 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 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 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 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?

5.57 Police officers submitted Adult Protection Investigation (APIs) notifications with risk assessments as a referral mechanism to the Protecting Vulnerable People (PVP) team at the local MASH. The Constabulary has no formal risk assessment tool to assess vulnerable adults. Instead, perceptions of risk are based on the professional judgement of officers in contact with the vulnerable adult. On review of the APIs submitted by the Police in this case, the IMR noted a lack of recognition of cumulative risk in the notifications. In August 2020, Doris was found to be at 'high' risk. The following month, (September) she was deemed to be at 'medium' risk, and a further API in September 2020 found that Doris was at 'standard' risk. API referrals

to Adult Social Care appear to have no highlighting of Chris's relevant offending history to inform risk assessment.

5.58 The Police IMR also found inconsistencies in the onward referral criteria between Police and ASC. The 'high' risk API from August 2020 did not meet the criteria for onward referral to ASC, but the 'medium' risk API undertaken in early September did.

5.59 On review of Police Adult Protection Investigations (APIs) it is apparent that issues relating to substance misuse and prior criminality were considered by officers with regards to the risks posed by Chris to Doris, and that an API was submitted to the MASH for Doris on 20 October 2020. However, no API was submitted by Police for Chris at any time.

5.60 At no point did Police categorise any incident between Doris and Chris as 'domestic-related' as the only information known to Police suggesting theirs was an intimate relationship came from family members (Laura and Jack). When questioned by Police, both Doris and Chris denied the existence of an intimate relationship, and officers saw nothing in Doris's home to suggest that the relationship was anything other than landlady / tenant. Subsequently, no DASH[49] RIC (risk assessment) was ever completed with Doris. The Police IMR noted that assessing for abuse and risk with older people with capacity is 'particularly difficult' if there is no intimate or familial relationship between victim and perpetrator. It is not certain at this time (December 2023) whether the new DARA Risk Assessment tool,[50] which was rolled out across the force area in February 2023, will address this issue.

5.61 ASC considered risks to Doris 'informally' and 'in conversation' with her, but a formal risk assessment was never completed. Doris's referral to the Eastern Locality Team in September 2020 should have prompted a Care Act assessment (including a risk assessment), but as discussed above, this assessment never took place, and Doris's case was closed.

5.62 There were 'brief references' to Chris's offending history on his ASC records (dated 2004, 2005 and 2017). The first record (from 2004) was that "Chris had been detained under Section 136[51] at Northgate hospital. Police were called by grandparents with whom he [Chris] lived. Had invited an ex-girlfriend round, became agitated with her and it is recorded, he assaulted her. Police arrived and he was agitated and tearful. Chris was noted as being on bail for rape. Noted that Doctors found no evidence of mental health illness, discharged from S136 and returned to his grandparents." The second record (from 2005 and recorded for information only) was "Father called into Nelson House with concerns for Chris (son). There is information noting an accusation of rape by a woman he worked with and sexual harassment by a woman he worked with. He can be aggressive and verbally abusive but is described as not being violent. Previously arrested for drunken behaviour. Father was considering having Chris live with him. Described as off sick with broken fingers. Advice given for Chris to seek medical advice with a possible

[49] Domestic Abuse Stalking & Harassment (DASH) risk assessment used to assess the level of risk faced by a victim of domestic abuse.

[50] For information on DARA, please see: https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-2022.pdf

[51] Section 136 of the Mental Health Act 1983 gives the police the power to remove a person from a public place when they appear to be suffering from a mental disorder to a place of safety. The person will be deemed by the police to be in immediate need of care and control as their behaviour is of concern.

referral via the mental health link worker. Advice given about calling Police should Chris be violent towards grandparents (paternal) who he currently lives with." The final reference (from 2017) was "Request for Care Act assessment (from Probation): Chris is reported to be diagnosed with borderline personality disorder, believes to be autistic (not diagnosed), would be going to district council for help with housing, looking for advice on any help that could be provided, advised he was a vulnerable adult and had been victim of abuse as a child and an adult. Was deemed 'safe for 3 days'. And later in 2017: Criminal liaison called to say that Chris had been arrested for theft of a prescription pad." There is no evidence that this past record was viewed by ASC practitioners.

5.63 A further note from 26 February 2021 on Doris's ASC record shows Laura referencing having seen Chris's Police charge sheet. Chris's offending history was not noted or taken into consideration by ASC during interactions with Doris, although it has since been found that SW3 did make reference to Chris's 'unpleasant' and 'intimidating' nature in an email to the Pathway Workers in April 2021 this is not specific enough nor the same as noting and sharing information on his previous criminal record or taking this into account in assessments, particularly of risk. Importantly, this information was not triangulated with additional information coming to ASC via the 'front door'. Additionally, the majority of ASC practitioners only accessed and recorded on Doris's record and did not view Chris's records. AP2 did access Chris's records on 16 September 2020, but there is no evidence that his case history was reviewed at this time.

5.64 The ASC IMR has found that a consistent feature of Doris's case was that ASC managers relied on the respective APs to provide them with an accurate case history to inform discussions / actions, but the APs failed to identify the accumulated risk. A learning point has been identified by ASC about all staff checking case histories before making decisions or giving advice. It would also be appropriate for all AP supervisors to ensure their staff have made full background checks.

5.65 A further learning point for ASC, concerning when to conduct a face-to-face visit, has already been embedded in local procedures since 22 December 2021. The new procedure states that face-to-face home visits must be carried out if two or more safeguarding concerns are raised. In addition, all SCCE managers must now explicitly state why a face-to-face visit is required when producing a case summary prior to referring a case to a locality team. This new activity is to be audited in the next systemic audit by the Quality Assurance team.

5.66 There is no evidence of any risk assessment tool being used with Doris at either of her GP surgeries. The IMR for the respective GPs in this review has found that there are no domestic abuse risk assessment templates available to staff using the primary care IT system. Additionally, local GPs are constrained in completing other established risk assessments (such as DASH RIC or DARA) due to the time constraints of 10-to-15-minute GP appointments.

5.67 The two Initial Sentence Plan risk assessments completed by the Probation service with Chris in August 2019 were found to be blank. A Review Sentence Plan assessment in September 2020 was completed, however, the respective IMR has found this assessment to be poor and lacking in information. Associated risk management plans were, therefore, insufficient.[52]

[52] The first and third assessments were completed by the same practitioner at the Probation service.

5.68 JPUH did not undertake any risk assessment with Doris as she did not appear to have any care and support needs and did not disclose any concerns about her home situation. If the EEAST referral had been received prior to Doris leaving hospital, she would have been asked if she felt safe to return home. The Hospital's Panel representative reported there is also a hospital Independent Domestic Violence Advocate (IDVA) staff can call on if required.

5.69 As Chris did not fully engage with Change Grow Live, no risk assessment was completed with him.

5.70 GYBC do not use a specific risk assessment tool or checklist. Concerns regarding Chris were discussed internally with the designated safeguarding officer and were twice brought to weekly Help Hub meetings.

5.71 Concerns relating to risk were passed by the EEAST to their Single Point of Contact for onward referral to ASC.

5.72 Failures in agencies identifying, assessing, and responding to risk feature significantly in the literature relating to statutory review frameworks such as DHRs (Home Office, 2021), SARs (Local Government Association, 2020), and MAPPA Serious Case Reviews (SCRs) (Mann, et al., 2023). Police, ASC, Probation service and GP assessments in this case were either not completed, or improperly completed by relevant practitioners.

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?[53]

5.73 Police did not consider the controlling and coercive offence, as there was no corroboration relating to information received from Laura and Chloe that Doris and Chris were in an intimate relationship. Officers made attempts to speak with Doris alone, and visited her the day after incidents were raised with them, and in June 2021, a Police sergeant did recognise that Doris may have been coerced into signing the 'tenancy agreement' and dispatched an officer to see her in person to identify any potential offences.

5.74 The ASC IMR identified several indicators of coercion and controlling behaviours perpetrated by Chris against Doris (Chris taking the phone from Doris and becoming angry with SW1 in September 2020; Doris disclosing that Chris had picked her up and put her in a room in February 2021; Doris changing the subject when Chris entered the room whilst she was talking to a social worker in March 2021; and Chris's protracted refusals to leave Doris's home when asked). However, none of these indicators were recognised by ASC staff as evidence of coercive and controlling behaviour, or domestic abuse even though Doris's daughter Laura used the term in conversation with the service's practitioners.

5.75 Some ASC practitioners evidenced in their recording that they had considered safe enquiry by asking Doris if she was free to speak without Chris being present (AP2 8 September 2020; AP2 22 September 2020; AP4 5 March 2021; SW2 24 May 2021; AP6 1 June 2021). On other occasions, staff did not record that they had

[53] For guidance on safe enquiry, please see: Local Government Association, 2015. Adult Safeguarding and Domestic Abuse, pg.38. Adult safeguarding and domestic abuse: a guide to support practitioners and managers: Second edition | Local Government Association

considered safe enquiry. No attempts were made to see Doris face-to-face away from Chris. There was a missed opportunity to arrange a face-to-face visit with Doris, away from Chris, when a visit had been requested to be carried out by Eastern Locality team.

5.76 Both of Doris's GP practices contacted her by telephone after being made aware of potential abuse perpetrated by Chris against her. The IMR for the respective GPs has acknowledged that this was not a safe method of communication with Doris, given the context of the information shared with them. There is no indication that either GP practice considered that Doris was being coercively controlled by Chris.

5.77 The Probation service was not aware that Chris was living with Doris, and so had no contact with Doris.

5.78 There is no evidence that Doris either raised concerns or was asked about her safety at home by staff at JPUH during her single visit to A & E.

5.79 When Change Grow Live contacted Doris to assess her welfare (either by telephone, or in person), they ensured that she was alone. Although they had some concerns for Doris their staff did not specifically identify Doris as being the victim of coercive and controlling behaviours from Chris.

5.80 The single telephone contact between Doris and GYBC was not conducted according to the principles of safe inquiry. However, concerns relating to coercive and controlling behaviours were consider, and these were escalated via the weekly Help Hub meetings.

5.81 Concerns relating to coercive and controlling behaviours were escalated by the Ambulance Service to ASC and Doris's GP.

5.82 The impact of coercive and controlling behaviour on victims of abuse is well established in the literature. Williamson (2010) has discussed the 'unreality' of a victim living with coercion and control, whereby perpetrators will construct and maintain a false reality, and then ensure that victims 'capitulate' to this reality through the use of emotional / psychological abuse, and 'sub-lethal violence' (see Myhill and Hohl, 2019). The statutory guidance framework (Home Office, 2015) on controlling or coercive behaviour further outlines the tactics used by abusers to ensure victim 'capitulation'. These are:

- isolating a person from their friends and family;
- depriving them of their basic needs;
- monitoring their time;
- monitoring a person via online communication tools or using spyware;
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep;
- depriving them of access to support services, such as specialist support or medical services;
- repeatedly putting them down such as telling them they are worthless;
- enforcing rules and activity which humiliate, degrade or dehumanise the victim;
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities;

- financial abuse including control of finances, such as only allowing a person a punitive allowance;
- threats to hurt or kill;
- threats to a child;
- threats to reveal or publish private information (e.g. threatening to 'out' someone);
- assault;
- criminal damage (such as destruction of household goods);
- rape;
- preventing a person from having access to transport or from working.

5.83 We now know, through family input and agency records that Chris was coercively controlling Doris during the period they were known to one another. Recent research from VKPP (2022) and Compass (2023)[54] suggests that this form of abuse is especially impactful on older people, as they may already be experiencing other vulnerabilities which abusers can exploit. The Compass (2023) research is helpful in understanding Doris's experience of coercive control. This research found that older people are often reluctant to disclose for the following reasons:

- Feelings of being a burden on their adult children and that they 'shouldn't make a fuss' can stop an older person from complaining if they feel the family member is being too controlling.
- An older person experiencing elder abuse from a spouse or other family member may also be reluctant to speak up because they feel they have limited alternative options for support.
- There might also be threats that much-needed practical help will be withdrawn if the older person doesn't, for example, change their will or sign over property the way the family member wants them to.
- If the older person lacks income or requires ongoing care, it can be hard to make others listen.
- With coercive control in particular, the older person may fear the consequences of standing up for their rights and speaking up. They might be told that if they complain, they will be punished—sent to an aged care home or not be allowed visitors.
- They may also fear they won't be believed if they haven't said something about the abuse earlier.

5.84 A further important fact in this case is Chris's use of self-harm (in this case, the cutting of his wrists, as described in 3.17 and 3.19) is consistent with a domestic abuser's use of coercive and controlling behaviour. Recent research (Fitzpatrick, et al., 2022) found "threats of self-harm and suicide were a tactic of coercive control men used against female partners. Together with other forms of physical, emotional, economic, and psychological controlling behaviour, threats of self-harm and suicide were intended to instil fear and exert power over women." It is of note that Chris used self-harm as a tactic of control when challenged by Doris in September 2020. It is conceivable that, as per the research cited here, Chris's actions "…appeared to be based on a belief that threats of self-harm would force women [in this case, Doris] into changing their behaviour." Doris was telling Chris he needed to move out, and by causing himself injury it is justifiable to suspect this was a method of to engender sympathy from Doris and manipulate her to change

[54] See: https://www.compass.info/featured-topics/coercive-control/understanding-coercive-control-as-elder-abuse/#section-why-dont-older-people-speak-up

her mind. Practitioners need to be alert to this behaviour as being part of coercive control.

5.85 The review identifies a lack of knowledge, and ability to identify, coercive control, and steps to take when it is identified. This is particularly apparent within Adult Social Care.

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.

5.86 The Police IMR states that no formal capacity assessments were conducted by Norfolk Police due to the fact that Laura had advised Police in August 2020 that Doris had recently been seen by medical professionals and was deemed to have capacity. Concerns were raised by Laura that Doris may have been suffering from early onset dementia, but officers interacting with Doris found that she was able to understand their actions, and the decisions she was making. Notwithstanding the above, when the Chair and Author met with Laura in March 2024, Laura challenged this Police record. She reported that there had been no formal assessments of capacity at this time, though she felt as though her mother had capacity with regards to taking her medication, but not with regards to risk. Laura felt as though the Police record was shifting the blame from them to Laura. When this issue was checked by the review Author with Police in April 2024, the API relating to this contact with Laura stated, "Her daughter [Laura] has been trying to arrange a doctor's appointment regarding concerns over Doris's mental wellbeing; however, they have last seen Doris one month ago and deemed Doris to have capacity – at present they have said that they cannot make a full assessment unless Doris agrees to this."

5.87 Initial attempts were made to assess Doris's capacity by SCCE after concerns were expressed by Laura on 6 September 2020. Laura advised that a nurse had told her there were no concerns about Doris's capacity or ability to manage her medication, but Laura remained concerned that her mother was making decisions she would not have made in previous years. The GP surgery was contacted to try to establish whether Doris had "an impairment of, or a disturbance in the functioning of, the mind or brain". This was in order to establish whether the first stage of the two-stage test set out in the Mental Capacity Act 2005, Code of Practice (2007) was met. The GP advised ASC that Doris did not have a diagnosis of any cognitive impairment or any condition that could affect here decision-making ability and mental capacity. The GP also advised there were no concerns on Doris's health record about her mental capacity. Laura challenged this record with the Chair and Author during a meeting in March 2024. Laura explained she felt that Doris's arachnoid cyst, which had caused Doris dizziness, had fundamentally changed her personality over the years. Doris was unable to understand the intentions of others, and this had made her vulnerable. As an example, Laura reported a time when her mother had befriended a local homeless woman who had a long history of substance misuse. This woman had told Doris she was 'going to win Miss America' and Doris and the woman would dress up and parade around the garden, as though they were contestants. Laura felt that Doris could not see how 'silly' this appeared to others.

5.88 Following the check with Doris's GP, SAPC1 advised AP2 to contact Doris to see if she could recall their previous conversation to clarify whether she was able to meet

her social care needs and to establish whether she was aware of the risks of inviting someone she didn't know to live with her. When Doris was contacted by AP2 she did not identify any unmet social care needs and it was described that "while [Doris] may have some memory issues, she appears to have capacity around the Care Act outcomes". The decision for consideration at this time was whether Doris had capacity to decide whether Chris should continue to live with her, not about Care Act outcomes. The decision to inform the initial information gathering for a mental capacity assessment had not been set out clearly. Despite this, the discussion with Doris did cover the fact that Chris continued to live with her and she said she was happy for him to reside with her. Initial enquiries based on GP information and a conversation with Doris led those involved to believe Doris wished for Chris to continue to live with her and that she had capacity to make that decision. It must be borne in mind that no face-to-face assessment took place, however.

5.89 When the above information was shared with Laura by ASC, Laura advised that Chris had been removed from Doris's property the previous week, and Doris was reported to have said she was "so relieved". However, Doris then seemed to have forgotten what had happened and invited Chris back into her home. AP2 discussed this with SAPC1 and at this point it was agreed Doris should be referred to Eastern Locality community care team for a face-to face Care Act and Mental Capacity Act assessment.

5.90 Doris's referral to the Eastern Locality team was picked up by SW1. Records show that SW1 contacted Doris first but when interviewed for the purposes of this review, SW1 said they recalled that they had contacted Laura first. SW1 has since been advised about recording in the correct chronological order. In conversation with SW1, Laura expressed concerns about Chris living with Doris. SW1 advised Laura that she would assess Doris's mental capacity with regard to this. SW1 contacted Doris via the telephone and asked some questions about her ability to manage her care needs and about who was living with her. Chris then took the phone from Doris and SW1 ended the call. There is no further recording on Doris's record about additional actions taken by SW1 at the time, beyond SW1 discussing the case with SAPC2. When SAPC2 was interviewed for this review, they said that they had not read Doris's record and that this was learning for them. SAPC2 accepted what SW1 had said (Doris had capacity, did not express any concerns about financial abuse - other forms of abuse not mentioned)) and did not have any Care Act needs, and therefore no safeguarding action was needed. Subsequent entries on LAS indicate that ASC assumed Doris had capacity and did not meet the criteria for safeguarding.

5.91 The ASC IMR has found the mental capacity assessment was not compliant with the Mental Capacity Act 2005 Code of Practice (2007), as the decision to be made was not clearly set out, Doris was not given every opportunity to make an informed decision herself, was not seen away from Chris, and was not given an opportunity to express what the possible outcomes of the decision could be.

5.92 A dementia assessment would not be carried out by a social care professional, but an attempt was made to establish whether Doris had dementia when her GP was contacted by AP2 and again by AP4 on 12 February 2021.

5.93 No distinction was made between decisional and executive capacity during ASC's involvement with Doris, and there is no evidence to suggest that the impact of coercion or control was taken into consideration when conversations were held about assessment of Doris's mental capacity.

5.94 As described above, Doris was assessed by a GP Partner on 16 February 2021 for capacity and dementia. The GP Partner found no concerns, though subsequent discussions with them have highlighted the limitations of such assessments having been conducted via the telephone, especially with regards to any potential impacts of coercion, or the possibility of Chris's presence.

5.95 Doris was not assessed in accordance with the MCA 2005 by staff at JPUH, as she was assumed to have capacity to make decisions about her care and treatment. Her attendance was also brief.

5.96 Change Grow Live had no grounds to undertake a capacity assessment with Doris and she appeared able to understand information provided to her and to communicate decisions she had made to the service's staff.

5.97 GYBC staff are not trained or qualified to conduct capacity assessments. Where there is doubt around a service-user's capacity, colleagues at Norfolk County Council Adult Social Care are informed and tasked with completing the assessment.

5.98 EEAST did not undertake an assessment of Doris's capacity, as concerns were escalated by them, as discussed above.

5.99 The Probation service had no knowledge of Doris, and so capacity assessments were not undertaken.

5.100 It is clear in this case that Doris's capacity was never appropriately explored in relation to her needs and to the risks that Chris posed to her. This failure to appropriately assess for capacity was due to two factors. First, requests from ASC to Doris's GP lacked specific detail as to why the request was being made, and second, ASC failed to give Doris the opportunity to express her own wishes and feelings away from Chris's influence in person.

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?

5.101 Mental Capacity Act assessments were not carried out properly by ASC as described above. Assumptions were made that Doris had capacity because the GP advised there was no diagnosis of any condition which constituted "an impairment of, or a disturbance in the functioning of, the mind or brain" and Doris communicated clearly that she was happy for Chris to remain living with her. Doris's expressed wishes were taken into account without question and without being set in the context of any risks to her safety. She presented as having decisional capacity and was able to say what she would do if she wanted Chris to leave, but it appears that she lacked executive capacity being unable to follow through on the actions she had initially said she would take.

5.102 Following the initial referral to Eastern Locality, assumptions were made that Doris's mental capacity had been assessed and Doris or Laura were frequently signposted to other sources of support such as the housing department, Police or Citizen's Advice Bureau. Doris's case was closed down on the basis that she had mental capacity with regard to Chris living with her and that she had no Care Act needs.

5.103 The GP undertook an MCA 2005 compliant assessment in February 2021 and concluded Doris had capacity. The notes do not specify the decision upon which capacity was being assessed. This assessment was completed by telephone in response to the social worker request for the GP to determine if Doris had capacity or impaired capacity. The GP partner has qualified that given the fact this was a telephone assessment it would be difficult to distinguish between decisional and executive capacity and if there was any impact of coercion. The GP arranged for Doris to attend for a monitoring blood test; she took medication for an underactive thyroid and osteoarthritis in her knees. It is unclear from the GP records what action ASC took in response to the capacity assessment completed. There is no record that the GP practice reviewed Doris's social circumstances again.

8. If Doris was found to be capacitous for the decision for Chris to remain in the home, was invoking 'inherent jurisdiction' considered as an option to safeguard Doris from his abuse?[55]

5.104 The level of risk to Doris was not identified and a risk assessment was not carried out by ASC. Inherent jurisdiction would only have been considered in cases where there is thought to be extremely high risk in order to remove a person from a situation to give them the best chance possible to make a decision without the undue influence of another person. The inherent jurisdiction of the High Court is an intervention of last resort that is considered by ASC only after all other options have been exhausted as it is a restrictive intervention which is contrary to the expressed wishes of a person with capacity. At the Chair and Author's meeting with Laura in March 2024, she challenged this response from ASC. Laura felt, given the information she had passed to ASC, the risk level should have been 'high', and she wanted to know what constituted 'high' risk in the opinion of ASC.

5.105 The ASC IMR found further assessments would have been needed before inherent jurisdiction was considered. Multi-agency partners could have been involved as appropriate using the Norfolk Safeguarding Adults Board's Complex Case guidance. If Doris's case had been brought under Section 42 of the Care Act, agencies could have been brought together to assess the risks to her and plan a coordinated multi-agency approach. Inherent jurisdiction would only have been considered if all of these options had been tried and had failed and if Doris was still felt to be at considerable risk.

5.106 Norfolk Police and Doris's GP found no evidence that the invocation of inherent jurisdiction was considered as a safeguarding option for Doris.

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.

5.107 The ASC IMR found numerous records where ASC practitioners spoke with Laura where her Laura's views were given consideration. For example, with regards to

[55] See: https://www.39essex.com/information-hub/insight/mental-capacity-guidance-note-inherent-jurisdiction [Accessed 21 November 2023].

mental capacity, on 9 September 2020 Laura suggested assessing Doris's capacity as she [Doris] was making decisions 'she would not have made a few years ago'. This prompted attempts to contact the GP surgery. Despite the GP advising Doris had no cognitive impairment, her case was sent to Eastern Locality for further assessment of mental capacity. On 24 June 2021, Laura rang and expressed concerns about Doris's "emotional memory", explaining how she would make a decision based on an incident with Chris, but then seemed to forget that she was afraid. At this point, Laura believed the Police were going to remove Chris and that therefore, the risk would be addressed. AP7 notified the Assistive Technology team who AP7 believed were going to do a face-to-face visit to assess for a community alarm. When the Assistive Technology practitioner carried out an assessment, Chris had temporarily moved out. Notwithstanding this input to the review from ASC, Laura challenged the finding during the Chair / Author's meeting with her in March 2024. Laura felt as though her voice was not heard, and the cumulative risks she consistently flagged with ASC were ignored by them. Laura wanted to know why this was the case, as she felt 'haunted' by ASC's responses.

5.108 With regards to changes over time that may have been indicative of cognitive difficulties not captured in conversations with Doris, on 16 September 2020, AP2 noted that Doris could not remember the conversation they had had the previous week which might indicate some memory loss. Doris's GP had subsequently been contacted for a diagnosis of cognitive impairment.

5.109 With regards to observations in all the different domains of everyday living, including for example the management of finances and/or self-neglect, ASC consider a person to meet the Care Act eligibility criteria if, as a result of a physical or mental impairment or illness, they are unable to achieve two of the following and that as a result, there is a detrimental impact on their wellbeing:

(a) managing and maintaining nutrition;
(b) maintaining personal hygiene;
(c) managing toilet needs;
(d) being appropriately clothed;
(e) being able to make use of the adult's home safely;
(f) maintaining a habitable home environment;
(g) developing and maintaining family or other personal relationships;
(h) accessing and engaging in work, training, education or volunteering;
(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services;
(j) carrying out any caring responsibilities the adult has for a child.

On 9 September 2020 a conversation was recorded by ASC with Laura wherein Laura advised that Doris was able to manage all of the above tasks independently at that time. However, at the meeting with the Chair and Author Laura challenged this record and advised there were elements of the list, specifically questions 'e', 'f', and 'g', that she would never have responded in the positive to. Laura also said she felt that parts of the list was inappropriate for use with older people.

5.110 A further conversation with Laura was recorded by ASC on 3 February 2021 when AP4 asked Laura what she believed her mother's care needs were. Laura explained that Doris's needs were around management of finances and her general vulnerability with regard to Chris living at her home. Laura advised that Doris's grandson [Jack] managed her bank accounts as Doris had got into some debt a few years ago. Laura said Doris went out independently but exposed herself to risk and was vulnerable to 'scams'. At this time, Laura suggested that Doris would be safer

in residential care or supported living. However, ASC records show that Laura asked for AP4 not to speak to Doris on this occasion as she would be unlikely to accept help and Laura was concerned she would then lose Doris's trust and Doris would stop telling her things. However, Laura remained concerned that even though Doris did not have physical care needs, she was vulnerable and unable to protect herself. AP4 discussed the matter with SAPC3 who advised seeking the GP's view on care needs and potential cognitive impairment. The GP reported Doris had capacity and did not have a diagnosed cognitive impairment, but she had been asked to attend the surgery for blood tests as a follow up. AP4 again spoke with Laura and explained that ASC would need to speak to Doris to obtain her consent for a referral. Laura was worried that Doris would know the concerns were raised by her and even though AP4 suggested advising Doris that the concerns were anonymous, Laura asked for the case to be closed. A consultation was held by AP4 with SAPC3 as a result. SAPC3 has since said that they did not look at the record and advised the case could be closed on the basis of the information communicated to them by AP4. With regards to this record, Laura told the Chair and Author that Doris, at this time, was giving Chris £90 per week to spend on alcohol. Jack was aware of this and had asked Doris to stop giving money to Chris. Doris had then asked Jack not to tell Laura what was happening. Laura went on to state that Doris had actually shared this information with her the next day, following the incident whereby Chris had lifted Doris up and put her into bed. Doris then also told Laura that she did not want Chris reported to the Local Authority for this action, and Laura had told ASC that if they were not prepared to take any action, then Doris should not be made aware of Laura's contact with ASC. Laura was clear that her request was that ASC should still take action against Chris.

5.111 In February 2021, Laura commented on changes in Doris's decision-making which was different to how it had been a few years previously. This was acted upon in that it prompted the beginnings of an assessment of Doris's capacity and contact with her GP. However, the information was not integrated into a formal mental capacity assessment when Doris's case was sent to Eastern Locality, nor when the GP was contacted again later in February 2021.

5.112 On 8 April 2021 a safeguarding concern was received by ASC from the Herring House Trust which was thought to have originated with Laura. Herring House records provided to this review show that this was not the case. Herring House had no contact with Laura. The concern was raised by an outreach worker there. Doris was contacted and said her daughter kept complaining to agencies and she herself had no concerns. The matter was closed on the advice of SCCE PC1 who believed this had already been investigated as there had been advice from SAPC3 to take no further action the previous month.

5.113 The ASC IMR found, based on the information provided by Laura, it was not clear Doris had any needs in the Care Act domains arising as a result of an impairment or illness. Further assessment was needed to identify whether that was the case, but this assessment did not take place.

5.114 ASC had no record of Doris sustaining a head injury, but with regards to the potential impacts of bereavement, on 9 September 2020 Laura spoke about the loss of Doris's two sons. Laura said Doris was actually more independent with daily tasks since the loss of her son who cared for her. Laura also felt Doris had not been able to process her grief and had tried to fill the void left by her sons by forming attachments with people who remind her of them, and this was why she believed Doris had formed an attachment to Chris. There is no explicit evidence that the impact of losing her sons was considered during decision-making about Doris's

case. There were missed opportunities for the impact of trauma to be recognised and for trauma informed approaches to be taken with Doris by ASC practitioners.

5.115 There is no evidence in Doris's GP records that the views of her family were considered. However, as Doris was deemed to have capacity, the GP would not have sought Laura's input without Doris's consent, and notes from February 2021 show ASC had informed the GP that Doris was not aware of the safeguarding concerns raised by Laura.

5.116 In February 2021, Laura's views regarding potential financial abuse were acknowledged by Doris's GP, but the record does not state which 'domains of everyday living' were explored with Doris.

5.117 With regards to issues around Doris's health records and head injury following a fall, Doris's GP has advised this review Doris attended the surgery in December 2012 with symptoms of persisting dizziness. During that period, Doris had fallen and banged her head. Due to the dizziness persisting she was subsequently referred to the Ear, Nose, and Throat (ENT) Department at JPUH. During review with ENT a scan identified bilateral arachnoid cysts. These are benign cysts (fluid-filled sacs) that grow in the brain and spinal cord. She was subsequently discharged in October 2013. There were no further symptoms mentioned in Doris's records relating to this fall or subsequent diagnosis. When Laura reviewed the draft report in March 2024, she felt strongly that Doris's fall had fundamentally changed her behaviour over time. Laura stated that this change was gradual at first, then more pronounced as time passed. Laura also felt this factor should have been considered in assessments by the GP and ASC beyond 2012.

5.118 In June 2021, a clinician at a Norfolk Medical Practice identified that Doris's son had passed away in December 2019 and he had been her carer. There is no record that this issue was explored further with Doris or Laura or that she was signposted for bereavement support as a result.

10. If it was the case that incidents involving Doris and Chris 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?

5.119 Following a review of the facts of this case, the Police IMR found enhanced multi-agency working arrangements would have provided agencies with a more holistic view of events, and a better understanding of cumulative risk. Closer working arrangements between the agencies represented in the local MASH, those working in Operational Partnership Teams (OPTs)[56] and practitioners in the Early Help Hubs (EHH) would prevent duplication of effort and ensure that appropriate support is provided. New referral mechanisms between the various fora would be helpful in terms of information-sharing, problem-solving, risk assessment, and safeguarding. There is also a need for Police and Probation services to work more closely outside of MAPPA and for Probation to be represented more consistently in Anti-Social Behaviour Action Group (ASBAG) and Early Help Hub meetings.

5.120 The ASC IMR found a number of areas in which multi-agency working arrangements could be improved locally. The first is around enhanced training for GPs on

[56] The OPT includes representatives from Norfolk Police, Housing Associations, and other agencies. The OPT works with both perpetrators and victims of anti-social behaviour to resolve any issues, whether this is with an individual or a group of people who are causing or suffering harm.

assessing for capacity and dementia. This suggestion is made on the basis that information from Doris's GP (that Doris had capacity and no cognitive impairment) in September 2020 was an obstacle in fully assessing her mental capacity, and negatively impacted decision-making at ASC thereafter.

5.121 ASC was not given details of Chris's criminal history in the 2020 referrals, which could and should have informed decision-making. There was no information available about a criminal history when the Police raised safeguarding concerns with ASC. However, a check on whether Chris was known to ASC would have shown they held records going back to a first contact in 2004 and again in 2005 which gave information from family members including allegations of assault of an ex-girlfriend and sexual harassment of a woman, plus aggressive behaviour. Eleven contacts in 2017 are recorded from Probation and criminal liaison and Mental Health which confirm his involvement with the criminal justice system. Had a Section 42 enquiry been raised, this may have come to light but conversely, a criminal history might have elevated the perceived level of risk to prompt a Section 42 referral to be raised if the ASC records had been checked. It would have been helpful if the Police or Probation service had shared information about the risk level even if they were not able to share specific offence details. There was a lack of joined up working between ASC and the Police with regard to removing Chris from Doris's home. The Crime and Disorder Act 1998 Section 115 empowers local authorities and agencies to share information in the prevention of crime, thus Chris's criminal history should have been shared, especially as he had previously moved in with a vulnerable adult, had exhibited violent behaviour, and there were allegations of offences against women.

5.122 ASC did not make direct contact with the GYBC housing department after Doris and Laura were signposted to them. SCCE shared information with the Mental Health Social Work Team but it was concluded that Chris did not have care and support needs and therefore there was no follow-up. It would have been helpful if ASC had worked with GYBC or the Herring House Trust to increase the priority of Chris for alternative housing, thus increasing Doris's safety.

5.123 The ASC IMR further identified a barrier that the safeguarding concern from the East of England Ambulance Service (EEAST) was not received until Doris had been discharged home from hospital in May 2021. The safeguarding concern was raised by EEAST on Saturday 22 May 2021, Doris was discharged from hospital the same day, but the referral was not accessed by the Social Work Team until Monday 24 May 2021 as the team does not operate over the weekend and does not have a permanent presence in the hospital. The ASC IMR suggests that there was a missed opportunity to speak with Doris on her own in the hospital environment, without the undue influence of Chris. However, Doris's attendance was of short duration which limited such opportunities and there was no social work presence on a Saturday.

5.124 The ASC IMR also found that "assumption of capacity" may have acted as a barrier in appropriately supporting Doris. The first principle of the Mental Capacity Act is that capacity must be assumed unless it can be established that the person lacks capacity. Whilst there is no evidence that this was the case for Doris, the IMR believes (with the benefit of hindsight) that too much weight was given to Doris saying that she was fine despite evidence at times to the contrary. There will be clarification about the assumption of capacity when the Code of Practice is

updated.[57] The new draft guidance emphasises that assuming capacity should not be used as a reason for not assessing capacity. If there is a "proper reason" to doubt the person lacks capacity, an assessment is necessary. The fact that Doris was behaving in a way her daughter felt was out of character and was putting her at risk would constitute a "proper reason" to assess capacity. As stated above, there was no evidence this was cited as a reason not to assess capacity, but it is believed the updated Code of Practice will bring much needed clarity regarding the first principle of the Mental Capacity Act.

5.125 The IMR submitted on behalf of Doris's GPs found on review of the records communication between agencies took place by email which may have affected the quality of the discussions. In order to better protect an adult at risk it would be reasonable for a direct telephone conversation to take place between professionals which is followed up with an email summarising the issues discussed.

5.126 The Probation service IMR identified an absence of information sharing between agencies and this had a significant impact on risk assessment and safeguarding for Doris. Since the time of Doris's homicide, there are now Police intelligence checks completed for every case at pre-sentence report stage. If these checks had been completed at the time, then the Probation practitioner would have been aware of the Police callouts involving Doris. If for some reason these checks are not undertaken at Court, it is identified during the allocation process by a Senior Probation Officer who then sets an action for the checks to be completed. The initial sentence plan including risk assessment is now completed within 15 working days of sentence. This is an organisational target and is monitored by line managers (senior Probation officers). In Chris's case, the initial sentence plan/risk assessment was countersigned by a line manager despite not being completed to the required standard due to an absence of information and failure to refer to previous Probation records. The initial sentence plan also now includes a risk assessment, risk summary and risk management plan where victims or potential victims are identified, factors linked to risk of harm and actions that will be undertaken in conjunction with other agencies to mitigate risks.

5.127 A Police report was made by staff at JPUH following Chris's threats to staff on 23 July 2021, and his GP was contacted by a hospital consultant regarding concerns about his behaviour. Since Doris's death, a Trust-wide communication has been sent to all staff reminding them to ask all patients whether they feel safe at home, to document any disclosures and to refer accordingly, with support from the JPUH safeguarding team. From the contacts with Doris described in this review she may not have disclosed she felt unsafe, but it is good practice to enquire and essential to ask the right probing questions to ensure the person feels safe to answer.

5.128 Change Grow Live received a referral for Chris from Alternative Provider Medical Services (APMS) who were contacted by them for further information around his physical and mental health. As Chris did not engage fully in treatment, Change Grow Live were unable to ascertain whether he was involved with other services. Consent is usually required from a service user to speak to other agencies; however, consent can be overridden if there are safeguarding concerns. Change Grow Live explored any concerns they had with Doris and were satisfied that she was speaking to the appropriate agencies (e.g., Police) for support. A MARAC referral was considered for Doris, but it was deemed the service did not have enough evidence to support a referral. A DASH RIC was reviewed by staff, but with the limited information

[57] Note: This matter will not be resolved within this government's term and will need to roll over until after the election (July 2024) and will then be dependent on prioritisation by the new government.

available to them, Doris's case was not deemed to have reached the 'high' risk MARAC threshold. However, a referral on 'professional judgement' could have been considered and this would have been a route to greater information sharing. Staff clearly had concerns and their 'gut instinct' caused them to review a DASH risk assessment. It is important for staff to listen to their 'instincts' and not be swayed by the number of ticks on a form. Professional judgement is just as valid to make a referral.

5.129 The GYBC IMR found through interviews with the staff who had contact with Chris and Doris, that they felt they experienced barriers in the form of other agencies / organisations not wanting to take forward the issue of Chris's controlling and coercive behaviour towards Doris when these concerns were brought to their attention. On two separate occasions different staff members at GYBC raised their concerns about Chris and they felt each time they were met by what appeared to be a lack of comprehension of the seriousness of the situation by other agencies and an unwillingness by these agencies to use their legal powers to take action against him. This indicates a lack of sufficient knowledge and understanding of the dangerous nature of coercive control and the insidious effect on the victims of this form of abuse. All staff involved in assessments need in-depth knowledge of coercive control (see analysis of Term of Reference 11 below).

5.130 Concerns regarding Doris were shared by EEAST through established channels.

5.131 During Panel discussions it became evident that there is a degree of confusion among agencies regarding the operation and roles of the various multi-agency groups within the county, including concerning the MASH. Expectations regarding what the MASH did far outstripped what takes place in reality. Although the MASH is a physical space with co-located agency staff, some agency staff were working from home a majority of the time which impedes informal discussions between staff and the practical means of multi-agency working. The MASH staff also operate on their own agency databases, there is no shared system, although this is not unusual. The assumption among some Panel members that the MASH was the hub for all safeguarding referrals proved not to be the case. Multi-agency coordination is thus limited. Had Doris's case been discussed in the MASH there is a chance that, although not formally recognised as domestic abuse, an IDVA would have recognised coercive control taking place and been able to suggest further actions to take including for example a Non-Molestation Order to keep Chris away from Doris.

5.132 At the time of writing (December 2023), Norfolk Safeguarding Adults Board and Norfolk Safeguarding Children Partnership are working on a piece of joint independent scrutiny that looks at the local multi-agency safeguarding hub arrangements. The aim of this scrutiny is to address practice gaps at the MASH and to ensure appropriate agency representation in the MASH.

5.133 Following the above update from the Norfolk Safeguarding Adults Board Manager, which was further discussed at panel in January 2024, the Independent Author for this DHR / SAR undertook a brief online search to determine what information was available to practitioners / the public with regards to the MASH.[58] This search found that the information provided on the Norfolk County Council webpages was significantly outdated with regards to those agencies represented at the MASH.

[58] See: https://www.norfolk.gov.uk/what-we-do-and-how-we-work/policy-performance-and-partnerships/partnerships/mash

5.134 Also, during panel discussions in January 2024, it became apparent that there was some confusion among local agencies regarding terminology applied to safeguarding 'concern', and safeguarding 'referrals' to Adult Social Care. For example, it was noted that some panel members took a safeguarding 'concern' to mean that a referral had been made to ASC. This, in fact, was determined not to be the case. To rectify this issue, the Norfolk Safeguarding Adults Board Manager has since advised:

> *The introduction of the Care Act 2014 made safeguarding adults a statutory responsibility and redefined the language used to describe it. The accompanying guidance sets out expectations of practice, in which the phrase 'vulnerable adult' was replaced with 'adults at risk'.*
>
> *The Care Act 2014 makes it clear that, abuse of adults links to circumstances, rather than the characteristics of the people experiencing the harm. Labelling groups of people as inherently 'vulnerable' is seen to be disempowering. The phase 'adults at risk' has been positively encouraged, see Norfolk Safeguarding Adults Board's multi-agency policy and procedures.*
>
> *The Norfolk Safeguarding Adults Board (NSAB) has, and continues to, promote the phase 'raising a safeguarding concern' rather than 'making a safeguarding referral'. While it is acknowledged that, the use of the word referral remains in common usage, it carries with it certain expectations that an action will be taken as a result of this information being shared. The decision whether or not a concern should be progressed under the Care Act as a formal safeguarding enquiry is the decision of the local authority.*
>
> *Commonly agreed language is important for establishing clear expectations of actions and supports shared understandings of roles and responsibilities. This encourages inter-agency awareness and the growth of partnerships working through shared understandings.*

5.135 At the same panel meeting (January 2024), confusion was also articulated by panel members with regards to practitioner / public awareness of adult safeguarding processes (e.g., and as mentioned above, the role of the local MASH in information sharing, decision-making), and the clarity / appropriateness of published materials. On review of the Norfolk Safeguarding Adults Board online 'flow-chart'[59] it was identified that the MASH did not feature in this resource.

11. Had the individual practitioners in contact with Doris and the 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

[59] See: https://www.norfolksafeguardingadultsboard.info/document/746/NSAB-END-TO-END-FLOW-DIAGRAM-2023.pdf?t=2f03c064f9aab2fd45a064f578d7cd601b1b25e5

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?

5.136 All Police officers attending incidents relating to Doris and Chris had previously received a full day training in domestic abuse and risk assessment as part of their initial training plan. The training is designed to cover adult family abuse, 'honour'-based abuse, financial abuse, and coercive control. In addition to this, all officers would have undertaken a further full day scenario-based practical training, based on live roleplay scenarios. Training around MARAC would not ordinarily be delivered to officers other than those working in the domestic abuse safeguarding team at the local MASH. At the time of writing, trauma-informed practice training is being rolled out across the force area. The Police IMR found the level of training accessed by relevant officers in this case was sufficient for them to discharge their duties and there were no conceptual barriers which prevented officers from responding appropriately to Doris and Chris.

5.137 The past recording of training for ASC staff is incomplete, due to variations in approach and recording. However, on review of relevant training accessed by practitioners in contact with Doris and Chris, the IMR found that:

- AP1's most recent (to Doris's homicide in 2021) training was Making Safeguarding Enquiries in May 2018.
- AP2's most recent training was Making Safeguarding Enquiries in June 2017 (this practitioner has since been instructed to undertake further training).
- AP3 undertook St Thomas Training safeguarding development session for APs in November 2018 and DASH RIC training in April 2021.
- AP4 undertook Making Safeguarding Enquiries in January 2019 and DASH RIC training in May 2022.
- AP5 undertook Safeguarding Adults Awareness in March 2019.
- AP6 undertook Making Safeguarding Enquiries in May 2018 (and has since been instructed to undertake additional safeguarding training).
- AP7 has since retired from ASC.
- SW1 undertook Making Safeguarding Enquiries in November 2020.
- SW2 undertook Making Safeguarding Enquiries in November 2021.
- SW3 undertook DASH RIC training in November 2021.
- SCCE PC1 undertook Making Safeguarding Enquiries in February 2021.
- SAPC1 undertook Learning Lessons from SARs[60] in July 2019.
- SAPC2 undertook Learning Lessons from SARs in in November 2019.
- SAPC3 undertook Learning Lessons from SARs in July 2018.

5.138 During interviews undertaken for the IMR with ASC staff, practitioners said they had not recognised Doris's situation as domestic abuse. Many thought that there had to be an intimate or familial relationship for domestic abuse to occur and did not realise that residing in the same household with a perpetrator of abuse is recognised as a criterium for a Domestic Homicide Review to be conducted.

[60] Safeguarding Adult Reviews.

5.139 During early contacts with ASC, Laura had said she suspected a sexual relationship between Doris and Chris based on things Doris has said to her (using language which was out of character). As part of the ASC learning review resulting from Doris's murder, ASC have considered that ageist assumptions about relationships between older women and younger men may have been at play. This may explain why the sexual relationship was not fully explored with Doris. Because practitioners were not reading back on the records, the allegation of possible sexual abuse was superseded when further allegations about financial, emotional, and physical abuse were received. Practitioners said they felt their training had been adequate but given these nuances were not known or not picked up, it suggests the training may have been lacking in sufficient detail to fundamentally inform and change practise. This has been addressed by commissioning a stand-alone course on domestic abuse and coercion and control via St Thomas Training, which began in April 2022.[61] With regards to this record, Laura told the Chair and Author, in March 2024, that Doris had told Laura and Chloe 'directly' that she was in a sexual relationship with Chris, and that they intended to marry. Laura further advised that this was made explicit to ASC and Police by herself and her daughter at the time. Laura also felt that the allegations of sexual abuse (referred to above) should not have been superseded by subsequent information regarding Doris's abuse but should have been considered as contextual to this.

5.140 ASC staff engaged with Doris and Chris had not undertaken any training on trauma-informed practice prior to Doris's death.

5.141 From April 2022, a refreshed programme of safeguarding training has been launched and this includes a standalone course on domestic abuse and coercive control. This is mandatory for all ASC staff.

5.142 All practice staff at both of Doris's GP surgeries had completed online training (via the Clarity Team Net application) which includes training resources, safeguarding practice policies, and safeguarding meeting minutes. This training is delivered annually.

5.143 Practice staff also have access to two clinical online training sessions which are based on relevant NICE guidance. The first of these covers assessment of domestic violence and abuse and takes approximately 30 minutes to complete. Areas covered include:

- The definition of domestic violence and abuse, prevalence, risk factors, complications. and consequences.
- How to recognize possible indicators of domestic violence and abuse.
- The definition of domestic violence and abuse.
- The risk factors for and consequences of domestic violence and abuse.
- How to identify possible indicators of domestic violence and abuse.
- How to assess someone with potential indicators of domestic violence and abuse.

The second module, which also takes around 30 minutes to complete, relates to the management of domestic violence and abuse[62]. Areas covered here are:

[61] See: https://www.stthomastraining.co.uk/

[62] There is no NICE guidance on the duration of domestic abuse training for GP's. https://www.nice.org.uk/guidance/ph50/chapter/1-recommendations#recommendation-6-ensure-trained-staff-ask-people-about-domestic-violence-and-abuse

- How to assess people with indicators of domestic violence and abuse, how to manage disclosures from victims and perpetrators, how to support them and when to share information.
- How to respond to a disclosure of a person experiencing or perpetrating domestic violence and abuse.
- About confidentiality issues and sharing information.
- How to support people experiencing or perpetrating domestic violence and abuse.
- About information sources to help healthcare professionals dealing with domestic violence and abuse.

5.144 In addition to the above, GP practice staff have access to a further online course on domestic violence and abuse awareness designed for all primary care staff to assist with their understanding of domestic violence and abuse, to increase awareness about the issue and how and when to apply it in their daily working lives. The 30-minute course contains a case study and multiple-choice questions. The course covers the following:

- The definition of domestic violence and abuse.
- The prevalence of domestic violence and abuse.
- The risk factors for and consequences of domestic violence and abuse.
- How to identify possible indicators of domestic violence and abuse.
- How to respond to a disclosure of a person experiencing or perpetrating domestic violence and abuse.
- About confidentiality issues and sharing information.

5.145 Trauma-informed practice is included within Level 3 joint safeguarding children and adult training provided by Norfolk and Waveney Integrated Care Board (ICB) monthly to all primary care staff. In addition, the ICB has provided an hour-long interactive webinar for primary care staff on trauma-informed practice and is in the process of constructing a Power Point presentation for staff as an online learning resource. Training sessions on trauma informed care were delivered for Learning Disability lead clinicians in November 2023 and for Safeguarding Lead GPs in March 2023 from all practices in Norfolk and Waveney.

5.146 One of Doris's GP practices has since requested a training update on adult family abuse, especially as it relates to the abuse of older people. Doris's other GP practice feels the level of training provided to staff there is sufficient. Both practices have a safeguarding lead GP, a safeguarding deputy clinician, and a domestic abuse champion. The single barrier to effective practice identified in the GPs' IMR was around the absence of professional curiosity in this case.

5.147 The Panel learnt that the Social Prescriber to whom Doris was referred for 'social issues and frailty' had not had domestic abuse training. Whilst direct intervention would be outside their role, it is important for them to have knowledge of specialist domestic abuse services from whom they can obtain specialist advice and support.

5.148 All Probation service staff are required to undertake one day training on domestic abuse and adult safeguarding. However, the practitioner in this case had not received the safeguarding training.

5.149 All clinical staff at JPUH receive mandatory level 3 Safeguarding training every 3 years in line with the requirements of the Intercollegiate Documents for Adults and

Children. This training package includes a dedicated session on domestic abuse. During the session staff are educated on controlling and coercive behaviours, signs that someone may be the victim of abuse and what to do if they are concerned about any service users. There is also a domestic abuse champions network within the Trust offering an additional layer of support to staff and service users.

5.150 As part of their induction, all Change Grow Live staff are required to undertake Safeguarding Adults at Risk training. This training covers:

- What is Adult Safeguarding?
- Discuss how some services and organisations have failed in the past.
- Review key pieces of legislation in place to support safeguarding across health and social care.
- What constitutes harm and why an individual may be vulnerable to harm or abuse as well as different types of abuse.
- Principles of Safeguarding.
- The Law.
- Learn how to spot the signs of abuse so you can protect the individuals you work and care for.
- Protecting people - what you need to do if you suspect abuse is occurring or if abuse is disclosed to you.
- Risk Management.
- Reporting Abuse.
- Have all the information you need to understand your responsibilities to safeguard adults in your workplace.

5.151 Each Change Grow Live locality team also has a domestic abuse champion. These roles are supported by attendance at a 2-day training event, hosted by Norfolk County Council. An additional MARAC awareness-raising session was conducted during a team meeting in February 2021, and this was attended by the recovery coordinator involved with Doris and Chris. Structured Regional Designated Safeguarding Lead (DSL) forums are held quarterly where learnings from DHRs alongside those from CSPRs[63] and SARs[64] are routinely discussed, distilled, and cascaded with the expectation that DSLs further cascade through local governance structures such as Multi-Disciplinary Team Meetings and safeguarding discussions to assimilate learning into local practice. It is a policy requirement that DSLs attend a minimum of 4 Regional forums annually (or send a representative in their stead) to ensure services remain connected to national updates, policy changes and wider organisational learning. The regional forums are further augmented by optional National Weekly Safeguarding Surgeries (chaired by the National Safeguarding Lead) that facilitate reflective practice and complex case discussion around statutory review learnings, as well as providing networking and peer support opportunities for CGL's Designated Safeguarding Leads.

5.152 All staff at GYBC Housing Options team have received the training mentioned in (a) to (e) above. All of this training apart from (d) formed part of a mandatory e-Learning package that all Council staff have to undertake on a regular basis. The training referred to in (d) above was delivered by Norwich Connect Spurgeon's' Children's Charity to the Council's Housing Options team.

[63] Child Safeguarding Practice Reviews.
[64] Safeguarding Adult Reviews

5.153 When interviewed for the purposes of this review, the GYBC Housing Service Manager felt the above e-Learning training package provided a basic overview and understanding of domestic abuse but was not really sufficient to meet the service's needs. In view of this, additional training has been sought and provided by Norfolk County Council and domestic abuse champions have been recruited.

5.154 EEAST staff are required to undertake initial safeguarding training on starting employment. There is then a rolling three-year programme of safeguarding content. Programmes are maintained on the internal Evolve system enabling EEAST to audit attendance. Domestic abuse training is central, in line with the Intercollegiate Documents which inform their training agenda. As no EEAST staff were interviewed for the purposes of this review, it has not been possible to determine a response to subsections (b) to (e) of this Term of Reference.

5.155 It is acknowledged that agencies in this case did not conceptualise the relationship between Doris and Chris as 'intimate', and so would not be considered as domestic abuse under the current legal definition. However, Doris's murder does meet the criteria for a Domestic Homicide Review (DHR) under DHR Statutory Guidance Section 2: 5 (b). Subsequently, the training outlined above may be appropriate in terms of informing agency responses to domestic abuse as per the current legal definition, but it is lacking in terms of the nuances required to identify and respond to cases of potential domestic homicide.

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 2020[65] onwards on service provision and the ability of services to support vulnerable members of society such as Doris?

5.156 The Police IMR found Chris continuously ignored government guidelines and Covid restrictions. The local beat manager dealt with each of these breaches, as they arose, resulting in Chris making a complaint about Police harassment. It does not appear Covid affected service provision in this case as resources were always deployed to deal with reported incidents. The only impact identified by Police was that partnership meetings were paused during Covid as seen in the Operational Partnership Team log of interventions. As a consequence, Chris was less visible to frontline officers due to being housed during Covid, initially in a bed and breakfast and then at Doris's home address. Pre-Covid, Chris was part of the homeless community and Police would regularly engage with him during routine patrols.

5.157 In September 2020, Laura advised ASC that Chris did not respect social distancing. Doris told APs 4 and 5 she believed her daughter did not like Chris because she and Chris had not had their Covid-19 vaccinations. Specific concerns were not raised with ASC about Doris's risk from Covid-19. If a mental capacity assessment had been required with regards to Doris's decision-making about Covid-19 restrictions and vaccinations, that would have needed to be carried out by a health practitioner rather than a social care practitioner.

[65] 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)

5.158 The ASC IMR found Covid-19 restrictions impacted very significantly in Doris's case. ASC was experiencing (and continues to experience) unprecedented demand and extreme stress and fatigue across the workforce. It is known that stress and pressure are key factors in reducing levels of professional curiosity. There were many examples in Doris's case where practitioners demonstrated a lack of professional curiosity. Most notably when SW1 did not follow up after Chris took the phone from Doris and began to speak angrily and in an agitated way to them, and also when AP6 referred to the Citizen's Advice Bureau after Doris rang asking for support to remove Chris from her home. Reports of alleged physical abuse (allegations that Chris picked Doris up and put her in her room and tied a piece of string round her finger) were not picked up and acted upon. Practitioners confirmed in interviews that they had not read back over the records due to the pressures and SAPCs advised that they had trusted the APs and SW1 to give them a full and accurate account to support their decision-making.

5.159 ASC home visits were restricted during the pandemic, with visits only allowed in circumstances where there was high risk. Doris's case was sent to Eastern Locality for a home visit, but her situation was not considered by SW1 to be high risk and therefore a visit did not take place. SW1 contacted SAPC2 before closing the case but did not discuss the case with a locality manager. A new procedure has since been developed requiring staff to consult with a manager before closing a case where there is outstanding risk and no plan for monitoring. The visits procedure has also been updated to specify that if there are 2 or more safeguarding concerns about the same person, a visit must be carried out. When presented with the draft review in March 2024, Laura expressed her strongly held view to the Chair and Author that that no Care Act duties had been altered by Covid restrictions, and ASC had a duty to respond to Doris's risks, even if it was perceived by ASC that she had no care and support needs at that time.

5.160 Over the course of the pandemic, recruitment and retention of staff at ASC became increasingly difficult with Eastern Locality being particularly affected by low staffing numbers. This was especially the case with low numbers of qualified staff and managers, which meant that remaining staff were under extreme pressure.

5.161 SCCE was under pressure because of a rise in the number of contacts to the department and issues with recruitment/retention of staff. The Discharge to Assess process, which was brought in at the start of the pandemic to ease the pressure on the hospitals, had an extremely detrimental impact on the social care front door as people discharged on the wrong pathway are directed to the ASC front door to meet the shortfall in care. In summer 2021, SCCE moved to business continuity measures and support needed to be requested from the rest of the ASC department. At this time, the safeguarding team also had a backlog of safeguarding consultations which SAPCs said may have impacted their professional curiosity and led them not to have read the records before making decisions, trusting what they were told by APs and missing nuances.

5.162 Since 2021, the safeguarding team at ASC has implemented a new model to manage its work. The new model builds in a greater accountability as all decision-making and rationale for decisions must be recorded by managers as an intrinsic part of the workflow process. The safeguarding team has carried out a reflective learning session about Doris's case and there is a commitment to read records thoroughly before making decisions when there is risk. The pressures in SCCE remain exceptionally high but there is a programme called "Connecting Communities" which is looking at remodelling the front door service to help manage demand. The Discharge to Assess process remains a significant problem for SCCE

with cases frequently directed incorrectly to the service. Work is ongoing to resolve this.

5.163 Pressures arising from the pandemic meant Doris was not seen in person by ASC. The ASC IMR surmised that such pressures may also have impacted on whether Doris was seen by her GP surgery and Doris being discharged home by JPUH on 21 May 2021, despite a safeguarding concern having been raised by EEAST. The IMR also suggested Doris will have been less visible in her local community at times of lockdown and more vulnerable to the impact of living with the alleged perpetrator.

5.164 Despite Government-led Covid-19 restrictions on patient contact, appointments continued to be provided by primary care by telephone consultation to minimise direct face-to-face contact. Doris attended her GP surgery twice for blood tests during this period.

5.165 The Probation service did not have any direct contact or knowledge of Doris and therefore did not take any actions in respect of breach of Covid restrictions. They were not involved with Chris's breaches of restrictions.

5.166 When attending JPUH, Chris was challenged about his refusal to wear a PPE mask.

5.167 Change Grow Live was not aware of any breaches of Covid restrictions. When Chris was referred to them, it was stated he was living with his mother, it was later ascertained that Doris was not his mother. Change Grow Live were not privy to the Doris's health record to assess her vulnerability. During the pandemic, the service's interactions with service users moved mainly to virtual, telephone, and video. However, some high-risk cases were seen face-to-face in line with Covid Infection Prevention Control (IPC) guidance. Chris's initial assessment was completed over the telephone as the service were still attempting to minimise face-to-face interactions to reduce the risk of contracting Covid-19 for service users and staff. However, the subsequent nurse's alcohol assessment was arranged to be face-to-face to ensure appropriate observations could be undertaken. Chris expressed concerns about Covid testing, however when he did attend the office he willingly answered the Covid screening questions, though he declined to wear a mask, stating he was exempt.

5.168 During the Covid pandemic, Great Yarmouth Borough Council (GYBC) operated the Government's 'Everyone In' programme which required local authorities to offer accommodation to all homeless individuals in their catchment area. Council resources were redirected to deliver this programme with some staff being redeployed from other services to assist with this task. The impact of the 'Everyone In' programme meant processing times for general Homeless Applications increased along with response times to email enquiries. GYBC's ability to help and support vulnerable individuals was unaffected as this was an area of particular focus with specific teams being setup to ensure vulnerable residents were provided with food, medicine and any other type of assistance needed i.e. loneliness support.

5.169 During lockdown, Chris was spoken to twice (25 March 2020 and 27 March 2020), using the intercom service at GYBC offices, as part of efforts to try and place him in accommodation. On both occasions, he left before a member of staff could see him. On a third occasion (31 March 2020) Chris was seen by two members of staff, and did have accommodation at a local guest house, though he had run out of money to pay for this accommodation. Chris was advised that he needed to claim Universal Credit to enable him to pay. On hearing this he became non-compliant

and verbally abusive, so the officers left the interview room and shortly after this Chris left the building of his own accord.

5.170 GYBC had no further interactions with Chris until 14 May 2020, when he sent an email advising he was likely to be homeless in a few days. A reply was sent to Chris advising him that in order for the Council to be able to help him he needed to follow Council procedure and make a Housing Application. Chris did not follow this advice and failed to make an application.

5.171 GYBC's final interaction with Chris during the lockdown period was during the phone call Doris made to the Council on 7 November 2020; it was only at this time that the Council became aware Chris was staying with Doris. During this telephone call there was no indication that Chris was contravening the lockdown rules or any information to suggested that Doris was classed as a potentially or clinically vulnerable person, therefore only low level general Covid advice was provided at this time.

5.172 EEAST attendances to Doris's home dealt with the emergency call that initiated the contact. EEAST did not hold caseloads, nor were they in receipt of patient information at the time of these incidents. It is now possible for EEAST clinicians attending a scene to access patient care summaries via iPads. The Trust will shortly be launching summary care record on the iPad so that clinicians can access medical history, care plans, mental health records etc. Whilst this was not available at the time of the EEAST attendances to Doris's home, this new practice should reduce similar occurrences as staff will be able to access other records held on systems.

5.173 Recent research from the VKPP (2022) is especially relevant in contextualising Doris's experiences of service provision during Covid-19 lockdowns. This research, paraphrased here, found that:

- There were more older victims (aged 65+) of domestic homicide during the pandemic compared with previous years…Victims were most often female, whilst suspects were most often male.
- Suspects of homicides involving older victims were not always known to Police for domestic abuse… However, the victim and/or suspect often had known care and support needs.
- …[D]disrupted support services to older couples and family members with caring responsibilities during the pandemic may have increased their risk of harm, including homicide.

To address these issues in future, the VKPP have recommended that:

- Agencies should ensure risk assessment tools sufficiently recognise the risk posed to older victims of intimate partner and adult family abuse.
- Agencies should discuss the needs of older victims during domestic abuse partnership meetings. Working with older victim charities and/or care associations, Police and partner agencies should also consider ways to reach out to older victims through accessible communications campaigns using a variety of methods (not just online or via social media).
- Older individuals with physical and/or mental care needs may be acutely vulnerable to abuse at home during future pandemics or social restrictions. Agencies must prioritise continued contact with these individuals in such circumstances.

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.

5.174 The Police IMR found officers used professional curiosity in their interactions with Doris and Chris and would regularly seek the views of family members. It should be noted that, when the Chair and Author met with Laura to discuss the draft review in March 2024, Laura strongly disputed this response from Norfolk Police. Laura explained there were no conversations between the Police and the family beyond those initiated by Laura and Chloe (when they raised concerns about Doris's safety). Laura also said she felt the Police had failed to use professional curiosity in understanding why Doris would allow Chris back into her home and in their understanding of Doris's capacity. Laura went on to state she felt the Police had also failed to use professional curiosity when she had reported Doris missing and she had to urge them to search Doris's home at this time. Laura added that she had seen blood in Doris's home on the day she went missing, but Chris had removed this by the time Laura had returned to Doris's home. Laura felt if the Police had undertaken a timelier search of Doris's home, they would have found the blood much more quickly. Laura went on to explain that when she had initially visited Doris's home, Chris had told her that Doris was out. When Laura noticed Doris's walking aid was still in her home, Chris advised that Doris had taken a spare aid with her when she left the house that day. However, Laura already knew that Doris had previously given away her spare walking aid and Chris was lying to her. When Laura communicated these concerns to Police, she was advised that Police could not open a missing persons file until the time of day that Chris stated Doris was due to return home. This, Laura felt, was further evidence that Police had failed to use professional curiosity and she wanted to know why the Police had believed Chris's story about Doris's whereabouts, but had ignored her concerns about her own mother? Laura further challenged the Police IMR findings by citing information she heard during Chris's criminal trial. During the trial, Laura recalled, the court was shown Police body-worn camera footage of the initial search conducted by Police of Doris's garden following her disappearance. In this footage, Police were seen to remove one of Doris's rings from a water butt in her garden. The officers could be heard discussing what to do with the ring and, Laura explained, had decided to leave the ring on an external window sill, rather than identifying the ring as potential evidence. Laura felt this was additional evidence that Police had failed to use professional curiosity in Doris's case.

5.175 The ASC IMR identified variations in the extent to which practitioners probed or encouraged Doris to express her wishes and feelings.

5.176 AP1 asked questions to establish whether Doris felt safe with Chris and about whether she needed any support. At the point of this engagement, Doris did not identify any concerns but had an opportunity to express them if necessary. According to the LAS record, SW1's conversation with Doris was very much focused on her ability to manage Care Act needs and SW1 did not check if she was able to speak freely. SW1 asked who Doris was living with and if there were any difficulties. SW1 believed Doris had capacity but did not take account of the fact she might be making unwise decisions and be at risk, and Adult Social Care could have supported her to mitigate the risks as far as possible. Doris was not able to respond fully as Chris took the phone and this was not followed up. SW1 said they did not want to be intrusive, but it is ASC's role to investigate properly, demonstrate curiosity and

intervene when necessary. SW1 did not record a full needs assessment on LAS documenting their assessment of Doris's care needs. These issues have been addressed with SW1 by the Eastern Locality Director of Integrated Care.

5.177 AP2 also gave Doris opportunities to discuss any support she needed. AP2 did not seem to pick up on the indicators of coercive and controlling behaviour such as Chris ringing to check who had called or speaking in the background telling Doris not to speak about him.

5.178 AP4 also gave Doris an opportunity to talk about any concerns, but at that time Doris was more focused on the needs of Chris. Doris stated that Chris was not aggressive to her, but she was able to talk about what she would do if he was threatening. AP4 did not explore how realistic Doris's answer was and how likely it was she would be able to enact it in the event that she was afraid. AP4 then focused on Doris's care needs. AP4 noted that Doris "changed tack" when Chris came into the room (beginning to talk about getting a shower installed downstairs) but this does not seem to have been picked up by AP4 as concerning or considered as a possible diversionary technique used by Doris to prevent an adverse reaction by Chris's to the phone call.

5.179 AP5's conversation with Doris focused on her care needs under the direction of Social Care Community Engagement (SCCE) PC1. AP5 asked about the tenancy agreement but accepted without question when Doris said she was happy that Chris was living with her. AP5's conversation with Doris seems to have been very much influenced by the fact that the matter had previously been sent to the locality with some consultation with the safeguarding team having taken place.

5.180 SW2 checked with Doris about whether Chris had been physically aggressive. They asked if Doris would like support to remove Chris from her home and asked her what she would do if the Chris became aggressive again. In this conversation, Doris was given reasonable opportunity to express her wishes and feelings, but the opportunity to ask probing questions about Chris's other possible abusive behaviours were missed.

5.181 AP6's intervention was insufficiently probing and lacked professional curiosity, failing to identify risk or offer support at a time when Doris was asking for help to remove Chris from her home. AP6 said they could not recall the case clearly but that they did not think they had considered prior contacts. Management discussions have been held with AP6 who has been asked to carry out further safeguarding training and has been reminded that if there is any indication of abuse, coercion or control, a manager must be consulted.

5.182 AP7 made no direct contact with Doris.

5.183 The GP at one of Doris's surgeries completed a capacity and dementia assessment with her on 16 February 2021 (via telephone), as requested by the Assistant Practitioner from ASC. The medical notes do not include a full record of the capacity assessment and it is not clear from the records the specific decision the capacity assessment was testing. It would seem the Assistant Practitioner was concerned specifically about Doris's ability to make a decision regarding her finances. Therefore, on reflection the GP IMR discovered, it would seem the GP surgery was not best placed to complete such a capacity assessment which may have been better completed by ASC. It does not appear that the email from ASC provided adequate information regarding the alleged financial abuse to adequately inform a full capacity assessment.

5.184 There is no record that the GP practice followed up the notification received from EEAST raising safeguarding concerns about Doris and it is unclear if this notification was seen by the GP when received. It is also unclear from the GP records if EEAST raised a safeguarding concern for Doris at this time. This appears to be a potential missed opportunity to use professional curiosity and follow up what happened or needed to happen as a result of the safeguarding concern.

5.185 On 18 June 2021, Doris disclosed domestic abuse to a clinical practitioner at her second GP surgery. It is apparent that the practitioner used professional curiosity at this time because they reviewed Doris's record after 2 weeks and discussed the case with GPs within the practice, ultimately making a referral to the social prescriber service. There seems a potential missed opportunity to discuss the option of a referral of a safeguarding referral with Doris and owing to the nature of the allegations it would have been preferable if Doris had been reviewed alone in clinic rather than by telephone consultation due to the risk of Chris being present. However, as Covid-19 restrictions at the time favoured telephone contact rather than direct contact, this may explain why this form of communication was used, however the practice assures that patients were reviewed both in clinic and at home with appropriate precautions if this was deemed necessary.

5.186 Norfolk and Waveney ICB have recently commissioned a series of full day training sessions for primary care on Mental Capacity Act and capacity assessments running between March 2022 and June 2023. Assessment of capacity is included in Level 3 Safeguarding Adult training provided monthly by Norfolk and Waveney ICB to primary care colleagues.

5.187 The Probation service did not have any direct contact or knowledge of Doris. Should Probation have been aware that Chris was residing with Doris, the expectation would have been for staff involved in this case to discuss any concerns Doris had and to undertake a home visit.

5.188 There is no documented evidence on JPUH records that Doris was asked questions during her A & E attendance or that she volunteered any information to staff.

5.189 The Change Grow Live IMR found staff followed up their concerns appropriately and when they spoke to Doris, they gave her the opportunity to explore her situation and asked about her safety. Staff had no consent to share information with Doris about Chris's involvement and as he was reluctant to engage in the service it was difficult to fully assess the domestic situation and associated risks.

5.190 The only contact GYBC had with Doris during the review period was a phone call instigated by her and she had the opportunity to discuss whatever she wished, however the GYBC IMR acknowledges that Chris was present at the time therefore Doris may have felt unable to express her opinions and discuss issues freely. The member of staff who received Doris's phone call was aware (based on their prior knowledge of Chris) that there was a possibility that Doris could be experiencing some controlling and coercive behaviour from Chris and raised her concerns about this with a colleague who then took the situation forward at the next multi-agency collaboration meeting. The knowledge and vigilance of the staff member demonstrates the value of staff with the organisational memory to recognise service users over time and act on their prior knowledge. This was an example of good practice.

5.191 EEAST staff are directed to use, where appropriate open-ended questions during interactions with service users. Documentation does not follow a proscribed list of questions - rather clinicians identify the concerns and then ask supporting questions to gain further information. It is clear from the referrals made and the documentation in this case that crews did receive information that caused concern. It is not possible to say if this was given voluntarily or as a result of questioning.

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.

5.192 The Police IMR identified two resourcing issues of note. The first was the lack of experience of frontline officers, and the short length of service the four officers had who dealt with the last incident at Doris's home. This is a national issue with policing due to recruitment and retention issues. The second issue relates to demand versus capacity issues within the MASH to review Adult Protection Investigations (APIs). There was a regular backlog of cases which were reviewed and managed by a Detective Inspector. Officers from outside the team in the MASH were used when demand outstripped capacity. Officers used were those who had previously worked within the MASH. Work is ongoing with the Detective Inspector to ensure levels of training and knowledge are consistent across all team members that review Adult Protection Investigations.

5.193 Resourcing issues at ASC have been fully discussed in the analysis of Term of Reference 12 (above). The pressures described here undoubtedly impacted on caseloads and supervision of staff. However, management support was always available to staff, and it is clear from Doris's case that SCCE practitioners sought advice from SCCE managers and the safeguarding team. SW1 spoke to SAPC2 but did not consult a manager in the Eastern Locality Team. However, ad hoc management support alone was not sufficient and regular - reflective caseload supervision was necessary. This has been identified as a point to be reinforced with ASC managers through monthly Team Manager / Practice Consultant meetings.

5.194 The GP's IMR has found no evidence of resourcing issues relevant in this case, however, it must be acknowledged that appointments of 10-15 minutes duration make undertaking a risk assessment very difficult.

5.195 During the period of Covid restrictions, the Probation service was operating under an exceptional delivery model (EDM). The impact on supervision in Chris's case was that his appointments would have been remote contact i.e., via telephone rather than in person. The records show that Chris was offered several telephone contacts with which he failed to comply. As Chris was not complying with his Order, the EDM is unlikely to have had an impact on best practice in this case. It should be noted however that the Courts were also operating under EDM which resulted in significant delays in Court hearings taking place. This did have an impact on Chris being sentenced both for the breach of his Community Order and subsequent offences. Had Chris been given a custodial sentence for his breaches of his Community Order and other offences, this would have provided Doris with the respite from Chris she needed and a chance to change door locks to improve her security.

5.196 There is no documented evidence on JPUH systems that there were any pressures or issues that may have affected the care and consideration given to Doris during her attendance.

5.197 The Change Grow Live IMR also finds no evidence of capacity or resource issues impacting interactions with Doris or Chris.

5.198 There was an increase in levels of staff absences at GYBC during the temporal scope of this review, but temporary agency staff were used to backfill for the period of time it took to recruit replacement staff. In addition, staff from other GYBC services were redeployed into frontline line work to ensure service delivery was maintained. There was no shortage of management support throughout this period and no restructures or changes to service contracts were conducted during this timeframe.

5.199 EEAST have found no evidence of resource pressures and all contacts with Doris and Chris were within target times set as part of the Ambulance Response Programme.

15. Were the actions or information sharing by those involved with either Doris or Chris 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?

5.200 All agencies returning IMRs found relevant information was shared in accordance with GDPR duties with the exception of Change Grow Live as they did not have consent from Chris to share his information with Doris.

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?

5.201 Object markers were put in place by Norfolk Police from 2 October 2020 onwards, which advised that a 'double crew' should be considered to attend and deal with Chris 'robustly'. The object marker detailed that Chris could be aggressive and he had been staying at Doris's address. It also detailed that Doris was very vulnerable and allowed Chris back into her home. Before this warning was in place, officers were passed information prior to attending informing them that Chris could be aggressive. The object marker was deemed effective as it resulted in urgent Police attendance on several occasions based on limited information, including when a silent phone call was made from Doris's home.

5.202 An additional marker was added by Police from 26 May 2021 onwards, which alerted officers that Doris was a repeat victim and there had been previous calls within the last 14 days.

5.203 CAD notes, secured for the purposes of this review, and relating to the final callout to Doris's address in July 2021, indicates the four attending officers were aware of Chris's criminal history prior to, and including the time he had spent living at Doris's home. The notes also state that Doris was 'vulnerable' and had tried on several occasions to remove Chris from her home.

5.204 There are no details recorded to show that Chris's previous criminal history was shared with support services i.e. with ASC on Adult Protection Investigation forms,

but they were as part of Anti-Social Behaviour Action Group and Early Help Hub meetings, when Police information was shared with partner agencies attending.

5.205 The Probation service IMR found there was no indication that information pertaining to callouts to Doris's address was shared with Probation staff by the Police or other agencies who were involved with her, or Chris.

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

5.206 Disclosure under the Domestic Violence Disclosure Scheme (or DVDS)[66] was not considered by Norfolk Police as it was not established that Doris and Chris were in a domestic relationship (i.e., partners or ex-partners). The Police understood that Doris was aware of Chris's offending as she was present during at least one arrest and when Police would call the address to update Chris in relation to current investigations, Doris would regularly answer the phone. Although Doris may have been aware that Chris had ongoing involvement with the Police and had court appearances, she was not officially fully informed about his offending history. Although Laura had seen a charge sheet relating to Chris, it is not clear whether Doris fully understood any ramifications for her in terms of risk posed by Chris.

5.207 In the IMRs submitted to this review, ASC, Ambulance Service, the GPs, and JPUH had no information relating to this Term of Reference. As Great Yarmouth BC were not directly involved in providing care and support to Doris, there were no lawful grounds for them to share information relating to Chris with her.

5.208 As the Probation service was not aware that Chris was living with Doris, disclosure in this case was not considered. Probation staff are aware they must consider disclosure to potential victims and will do so in conjunction with relevant partner agencies, as appropriate.

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?

5.209 In the Probation service's breach report dated 30 July 2019, Chris's poor compliance was outlined to the Court and the recommendation was for the Order to continue. It is common practice for a 'response to supervision' report to be completed in the event of further offences occurring during the operational period of a Community Order, however this did not happen in Chris's case. There are indications, however, in the contact logs that Probation staff were concerned about the likelihood of Chris complying with any further community disposals due to his history of failing to engage and comply. The Probation service IMR considers the Court was given the necessary information to inform sentencing in this case.

19. Was management and supervision of Chris sufficiently robust, in line with Probation service 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 person and his criminal history?

[66] The Domestic Violence Disclosure Scheme (DVDS), also known as "Clare's Law" enables the Police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. See: Domestic Violence Disclosure Scheme factsheet - GOV.UK

5.210 In line with Probation procedures, the IMR identified Chris's failure to comply with instructions to attend appointments was enforced in a timely and appropriate manner, although arguably this was with limited success. There were subsequent efforts to re-engage Chris which is demonstrative of good practice.

5.211 However, there was an insufficient level of liaison between the Probation service and other agencies such as the Police, ASC, and Mental Health Services. It is Probation procedure to request Police intelligence checks for all cases going through court and in the event of poor engagement and further offending. This was not completed in Chris's case. While the Probation Practitioner identified concerns relating to Chris's mental health, there was no ASC referral or MASH checks undertaken. If these had been completed, the practitioner would have been able to complete a fully informed risk assessment and risk management plan as well as undertaking a home visit. The risk assessment and sentence plans for this case are blank in sections and were not reviewed following significant events such as further convictions. The conclusion is that the Probation service's supervision of Chris was not sufficiently robust.

20. Were the Police informed of Chris's supervision by the Probation service and the orders to which he was subject? If not, why not?

5.212 It is not common practice for the Police to be notified of cases that are under the supervision of the Probation service. There are exceptions to this in cases where there are particular risk concerns. In this case, the Probation service was not aware that Chris was living in Doris's home.

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

5.213 The Probation service has no record of any liaison with the Police in this case. The log of the calls to Police was reviewed and there is no mention of information being given to officers in relation to any supervision arrangements Chris had with the Probation service.

22. Did agencies in contact with Doris and Chris consider the potential for Chris to be 'cuckooing'[67] Doris at any time? Are staff trained to recognise 'cuckooing'? Did the staff in contact with the Doris and/or Chris, or in a supervisory position have training and knowledge of 'cuckooing'?

5.214 The Police IMR confirms 'cuckooing' is not a new concept for policing, and the Constabulary has been raising awareness and training officers for a number of years as part of the training they provide on 'County Lines'. Norfolk Police have a

[67] 'Cuckooing' is defined here as: A practice where people take over a person's home and use the property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds.
• There are different types of cuckooing:
• Using the property to deal, store or take drugs
• Using the property to sex work
• Taking over the property as a place for them to live
• Taking over the property to financially abuse the tenant
• The most common form of cuckooing is where drug dealers take over a person's home and use it to store or distribute drugs.
See Norfolk OPCC, n.d. Available at: https://www.norfolk-pcc.gov.uk/who-we-are/community-safety-partnership/our-priorities/exploitation/

'County Lines' team that specifically deal with drug related exploitation and the local Operational Partnership Teams (OPT) and Neighbourhood Policing Teams deal with lower levels of this type of criminality. The Police IMR covers the involvement the OPT had with Doris and Chris in this case and they were involved due to their concerns of Chris's previous criminal history and the fact he was now living with a vulnerable adult. Although officers did not refer to the situation as 'cuckooing', they took all the necessary steps available to them to try and engage with Doris to safeguard her on proactive visits to the address, as well as discuss their concerns with partner agencies. It is of note that Norfolk Police do not have a standalone policy for 'cuckooing', instead, it is mentioned briefly in the Adult Abuse Investigation policy[68] as a form of abuse. When the Chair and Author met with Laura she challenged this finding. Laura asked for clarification with regards to what was meant by 'all necessary steps' and where Police had evidence of 'proactive' visits to her mother?

5.215 The ASC IMR states that 'cuckooing' risks were not explicitly documented in relation to Doris' situation on her records. Mandatory Safeguarding Adults Training at Norfolk County Council does, however, cover such issues.

5.216 There is no evidence within the records held at JPUH that 'cuckooing' had been considered or recognition that it should be contemplated in this case.

5.217 The Probation service was not aware of the relationship between Chris and Doris therefore the prospect of 'cuckooing' was not considered by the practitioners involved in this case. There is no specific training for staff in respect of 'cuckooing', however this is a concept widely known in the Probation service and the topic is touched upon within other training.

5.218 At the time of their engagements with Doris and Chris, CGL staff involved with Chris had knowledge and awareness of cuckooing through attendance at workshops. Awareness had previously been raised around 'cuckooing' as a drug related county lines activity. This review highlights the need to consider the practice in a wider context than county lines.

5.219 Neither of the GP surgeries featured in this review considered Doris to be at risk of cuckooing, nor had they received any training on the issue. The surgeries have committed to incorporating this topic and learning in future Adult Safeguarding meetings.

5.220 The Ambulance Service (EEAST) had concerns that Doris was being 'cuckooed' by Chris, as evidenced by referrals from EEAST for Doris in March and May 2021, and for Chris in March 2021. However, it is noted by the Chair and Author that the term 'cuckooing' is not explicitly stated in the EEAST chronology or IMR. Cuckooing is part of the Level 2 safeguarding training which is undertaken by all patient facing staff prior to becoming operational. The training is in line with the guidance of the Intercollegiate Documents for Adults and Children. EEAST registrants also complete the level three training in line with the guidance of Intercollegiate Documents for Adults and Children. This includes a four-hour delivery (face-to-face via MS TEAMs presented by the EEAST Safeguarding Team which also includes cuckooing both as a recap and part of a set scenario. All staff in contact with Doris and Chris had undergone this training.

[68] Found in Sct. 6.1 of this policy.

5.221 The nature of this case demonstrates the need to view 'cuckooing' behaviour outside the context of 'county lines'.

23. Are there any similarities between the facts, themes, or learning from this review arising from prior local DHRs or SARs?

5.222 Previous DHRs within the county involving older people have identified similar themes or learning emerging from this review, these include:

- The importance of speaking in person to older adults to hear their views and to assess capacity.
- Listening and taking seriously the concerns raised by family members.
- An absence of 'professional curiosity'.
- Inadequate identification of coercive control affecting older adults.
- Inadequate identification of risk and risk assessment.
- Absence of information sharing.
- A lack of coordination between services.
- Resource shortfalls particularly in Adult Social Care.

24. Have any examples of effective practice been identified in this case?

5.223 The ASC IMR has identified the following areas of good practice in this case:

- SCCE APs regularly checked with managers regarding Care Act needs/mental capacity/risk and safety planning.
- There were many occasions when practitioners checked if Doris could speak to them freely without Chris being in the room.
- The GP was consulted about mental capacity (although the questions to the GP were not framed well by APs).
- The SAPC appropriately and proportionately requested a face-to-face visit for an MCA and Care Act assessment in September 2020.
- The referral received on 24 May 2021 from the EEAST was well explored by the JPUH social worker, particularly as this was received from EEAST some 2 days after the incident and after Doris had left the hospital. The social worker phoned Doris and ideally the case could have been put through to the locality team and a visit carried out, but the JPUH social worker felt they did what they could with the information received. The social worker referred on for assistive technology support for falls.

When the Chair and Author met with Laura to discuss the draft review, Laura challenged this input from ASC and asked when, specifically, were the occasions when ASC checked that Doris could speak freely, also could ASC quantify what is meant by 'well explored' in this instance, and what other information was considered by them at the time. When Laura's challenge to ASC was further explored by the review Author, the ASC panel member's response was that staff explicitly checked that Doris was able to speak freely during 2 calls to her on 6 September 2020, and during a further call on 22 May 2021. The ASC panel member conceded that these were the only 2 occasions (from a total of 9) when staff recorded that they had checked that Doris was able to speak freely. With regards to Laura's challenge that Doris's needs were not 'well-explored' by the social worker in May 2021, ASC have provided a lengthy record relating to this contact which does evidence that the social worker extensively explored Doris's current situation (with regards to her health, the nature and dynamics of Chris's presence in her home, safety planning, any further support required, and an onward referral to the assistive technology services).

5.224 The Probation service IMR identified evidence of good practice by the Pre-Sentence Report author to request a mental health assessment for Chris in this case. Additionally, enforcement action was undertaken in an efficient and appropriate manner. There were extensive attempts to re-engage Chris following the breach of his Order.

5.225 The GYBC IMR highlighted the multi-agency collaboration meetings held each week as an effective forum for agencies to bring cases / individuals they are concerned about before a wider audience to seek help / support / assistance for the relevant individuals. The effectiveness of the meetings relies on regular attendance from partner agencies and organisations, this attendance needs to be maintained to ensure these meetings remain effective. The review also identified the work of the staff member who identified the importance of their past knowledge of Chris and bring his past history to the attention of the meeting as good practice.

5.226 The Change Grow Live IMR found although Doris was not in their service and being supported by them, action was taken to ensure her welfare.

5.227 The EEAST IMR found crews documented and acted upon concerns they identified in a timely manner and in line with procedures.

6. Conclusions

6.1 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.

6.2 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.

6.3 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.

6.4 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.

6.5 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.

6.6 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.

6.7 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'.

6.8 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.

6.9 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.

6.10 Below is an abridged statement by Laura on the findings of the Review. *(Laura's full statement is placed at Appendix B).*

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

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.

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.

A copy of Laura's full statement can be found at Appendix B on page 126.

7. Lessons to be Learnt

Listening to Families

7.1 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's offending history, but this vital information was ignored.

7.2 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.

7.3 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 (see paragraph 7.7 final bullet point below).

Recognition of Coercive Control and Links to Cuckooing

7.4 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.

7.5 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.

7.6 Although traditionally connected with 'county lines' and drug dealers taking over the homes of vulnerable people, cuckooing[69] 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 Home Office (2023) publication on the criminal exploitation of children and vulnerable adults as used by those who 'cuckoo' vulnerable adults.

7.7 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.

7.8 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,

[69] 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.

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

7.9 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.

7.10 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).

7.11 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[70]) 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.

7.12 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.

7.13 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.

7.14 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

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

identify and mitigate risk. What appears to be a reluctance to undertake Section 42 enquiries needs to change.

7.15 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

7.16 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.

7.17 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.

7.18 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

7.19 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.

7.20 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's 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.

7.21 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[71] and the part this can play as a result of coercion and control over time. There are key symptoms of Stockholm Syndrome[72] 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.
- 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.

7.22 Research for 'Safe Care at Home' (2023[73]) 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.

[71] 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.
[72] Stockholm Syndrome in Relationships: Impact On Mental Health (simplypsychology.org)
[73] Safe Care at Home, June 2023, HM Government. Safe_Care_at_Home_Review_.pdf (publishing.service.gov.uk)

7.23 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.

7.24 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

7.25 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.[74] 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.

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

7.27 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.

7.28 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

[74] 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

own records for Chris's background which would have revealed this crucial information.

Multi Agency Coordinated Response

7.29 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.

7.30 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.

7.31 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.

7.32 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.

7.33 A common understanding of terminology, provision, and processes is key to an effective multi-agency response. As discussed in 5.134, and 6.9 (above), 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

7.34 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.

7.35 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'.

7.36 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

7.37 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.

7.38 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.

8. Recommendations

8.1 The following recommendations arise from the lessons learnt, Panel discussions, and the respective IMRs submitted to 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.[75]

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.

[75] 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.

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.

East of England Ambulance Service NHS Trust

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

APPENDIX A

Chair/Author's Relevant Career History & Experience

The Review Chair:

Gaynor Mears OBE holds a master's degree in Professional Child Care Practice (Child Protection) during which she made a particular study of domestic abuse and its impact, the efficacy of multi-agency working and the community coordinated response to domestic abuse. She holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification, and 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.

Gaynor Mears has extensive experience spread over more than 20 years of working in the domestic abuse field. This included roles as a county domestic abuse reduction coordinator during which she set up a countywide IDVA Service, and as a community safety manager working with Community Safety Partnerships and across a wide variety of partnerships and agencies, both in the statutory and voluntary sector.

Gaynor Mears was regional policy lead for domestic and sexual violence at the Government Office for the Eastern Region and was a member of a Home Office task group advising areas on the coordinated response to domestic violence and abuse. During her time at Government Office, she worked on the regional roll-out of IDVA Services, MARAC, Sexual Assault Referral Centres, Specialist Domestic Violence Courts, and supported Partnerships with their implementation. As an independent consultant Gaynor Mears has undertaken research and evaluations into domestic abuse services and best practice, and since DHRs were introduced in 2011 she has undertaken Review chair's training and undertaken a large number of reviews covering both intimate partner violence homicides and adult family violence homicides. Gaynor Mears has also served as a trustee of a charity delivering Respect accredited community perpetrator programmes. She regularly updates her training and endeavours to keep up to date with research,

Gaynor Mears meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of training, and the experience required for the role.

The Review Author:

Simon Kerss is an Honorary Fellow with the International Policing and Public Protection Research Institute 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.

In addition to these roles, Simon works as an Independent Domestic Homicide Review (DHR) Chair/Author, He has contributed to, or led on, other DHRs as a practitioner, commissioner, and IMR author. These DHRs and joint reviews have included issues of modern-day slavery, trafficking, HBV, child / adult safeguarding, suicide, 'collateral homicide', substance misuse, mental health, adolescent to parent violence, and adult family violence.

As the country's first male Domestic Violence Coordinator (later, Domestic Abuse and Sexual Violence Partnership Manager), Simon 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.

Simon's ties to the voluntary sector have remained strong throughout his career. He has volunteered as an advisor to a local women's charity since 2007 and has worked in partnership with specialist services as a practitioner, strategic manager, and commissioner. He is a special academic advisor to the national charity Embrace: Child Victims of Crime and also currently works as a peer review cadre member for the College of Policing's Vulnerability Knowledge & Practice Programme, acting as the academic advisor to a multi-agency team of 'inspectors' assessing Police responses to issues of domestic abuse, child abuse / sexual exploitation, and other areas of Police 'vulnerability'.

Prior to the above, Simon worked with vulnerable teenagers in a variety of roles in Children's Services across Suffolk and Cambridgeshire including the Connexions Service, Youth Service, Youth Offending Team and Children's Social Care.

Simon meets 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 for the role.

APPENDIX B

Full Statement by Laura, Doris's Daughter

The various legislation that surrounds the safeguarding of adults exists to protect people's 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. Police could have done more to understand the sexual relationship between my mum and Chris that I reported to agencies. When, in the early days of the abuse, my mum had told my daughter she was having sex with Chris and, a day later, told me that she would marry him and leave him her house. I did not know, until after the trial, that they had asked my mum and Chris and they denied it. Nobody told me this. In fact I assumed that the fact of their relationship had been accepted. Had they inquired further I could have told them that Chris had moved a double bed down the stairs, into my mums downstairs en-suite room (she couldn't manage the stairs). I could have told them that every time I spoke to my mum Chris was present because they were sharing a room together. They could have spoken to my mum on another occasion about this, without Chris present. They could have offered for my mum to have myself or an independent advocate, present in that discussion.

The police could have asked themselves the question, whether the fact that my mum kept letting him 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 as time progressed.

And this really matters because Chris's abuse of my mum followed a pattern I know now to be typical of domestic abuse. In particular that he became over time, increasingly entitled to my mum and her property. Rather than seeing the tenancy agreement as their ticket to inaction, the police could, if they had been professionally curious, seen it for what it was, a progression in this man's attempt to take over my mum's property. A warning sign of the escalation of the entitlement that led to him feeling, finally, that he could take my mums home from her.

The police could have asked themselves the question whether my mum inviting this younger, 39 year old man into her home was indicative of her cognitive frailty. Given the context for

this it would have been an obvious question to ask. 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 that 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.

The review makes mention of the police not letting family know about his criminal history. I would settle for them just taking it seriously themselves. They were the ones, always, with the power to remove him. They could have communicated with the probation service (I did not know Chris was on probation, they did), who could have carried out a risk assessment (or at least completed the blank ones submitted for this review), but the probation service did not even know that he had moved into my mums house.

They could, though, have contacted me to find out more about my mum and the situation. They knew I was very involved in my mum's life. They didn't. There was no proactive consulting with family. The only times I engaged with the police was in relation to incidents.

At the most basic level professional curiosity would have led the police to question my mums ability to make and/or execute the decisions needed to keep her safe, but they didn't. Thinking back to that evening in June when my mum asked me to help her call the police to evict him, it breaks my heart to think that even then, when she really wanted him out of her house, no-one would help her. In fact the response of the officer on that night was 'well, we did tell you not to let him back in didn't we'

And despite the fact that the tenancy agreement Chris himself had drawn up, and was now waving about in front of the officers faces, was itself was not legally valid the police continued to uphold it. Had they really seen the risk they would have been looking for ways to get him out, not telling me and my mum, exhausted by fear and the demoralizing impact of being ignored, that it is now a 'civil matter'.

Had the police used professional curiosity they would have seen the risk and acted on it. They did not. Perhaps the most striking example of this were the hours surrounding my mums murder.

My mum was so frightened the night of her murder, that she went across the road, with her walking frame, to a neighbour. I visited that neighbour s house last year to ask them about it. They told me she was crying. My mum told this neighbour that she hadn't seen him so bad. He had been throwing pots around the kitchen because she had burnt some pasta. The four police officers who arrived did not arrest Chris. They sent him away to calm down told him not to come back until the following day.

In the response I received from the IOPC, one of the officers interviewed said that when she went to the incident that night the only thing she knew about my mum was that both my mum and Chris were heavy drinkers. Aside from it being not true that my mum was a heavy drinker (there is no evidence anywhere to suggest this is the case), there was so much more that this officer should have known in order to make the judgement she made.

During the trial Chris said he had gone back to my mum's house that night because it was cold. He wanted a blanket. Curiosity may have allowed the officers to see that he would not stay away for long or at least to question whether, given he was only wearing a t-shirt, given that it was a cold night for July, he would stay away all night. I was at an outside folk event, everyone was wrapped in coats and jumpers, by the time I drove home it was foggy. I saw the CCTV footage of the night. Chris clutching his tenancy agreement (his certificate of entitlement to my mum's property) as he walked away and then back to my mum's house.

I struggle to understand why, given the history, given the context, the police would have thought he wouldn't return.

The morning of 25 July I called police after seeing a small smear of blood on my mums door when I went round to take her paper and some shopping. This led me to knock on the door (and walk back to the garden gate as I was afraid of Chris). He opened the door. I saw my mum's walking frame. He lied. Said the smear of blood was sauce. I said it wasn't. I know what blood looks like. He changed his story, said my mum threw something at him cutting his hand. He said she was out. I said she can't be, her walker is there. He said she had gone with her spare. I said she couldn't have, she gave her spare away a couple of weeks back. I dialled 999. Told them everything. The police attended. We stood together in my mums room, the blood wiped from the door, her walker frame placed now in her room and the police listened to Chris. They asked what time my mum would usually come home. He said 5pm. On a Sunday! They said there is nothing they can do until that time but they would have a look for her in town. They didn't. I did. My daughter and I walked into town to look for her in the all the places in town she might have gone. We couldn't find her. Called the police again. Only because I insisted did they come back to the house with me to look inside the house for my mum.

The pieces were all there.

At that time, I did not know about the incident the night before. Yet even without this knowledge I was so afraid that, after that first visit, my hands shook. I said the police officer, look, my hands are shaking. Despite their knowledge of the night before. Despite the many, many violent incidents of the past 16 months. Despite all they knew about Chris's violent history that I did not, they insisted they couldn't treat my mum as missing until the time that Chris said she would usually come home.

And this matters especially, because the first time I called the police and went to the house, my mums body was still burning in the back garden. By the time of the second visit, several hours later, when we did go into the garden, there was nothing left. Those hours in between are likely to have meant the difference between unidentifiable fragments and identifiable remains. It may have reduced that agonizing period of not knowing if they would find a piece large enough to contain any DNA and it may have given us more than a small box of ash to bury.

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, as I articulated the escalating risk in that house, 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 draft 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 her (intermittently, between escalations of violence) in order 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 voice, of rights, of risk. I am now a safeguarding lead. I train the 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 in this. 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 even only me raising the alarm. Concerns came from many agencies, police, housing, ambulance, even my mum's plumber raised safeguarding concerns.

During the last concern raised, June 2021, the month before my mum's murder, a social prescriber, also raised his concern. My mum had told him on three occasions, she wants him out. The social prescriber called me, he said he was worried about her safety. In response the local authority officer, said my mum told them she wants him there. They did not even, on that occasion, phone her.

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 empowered by the repeated indifference of so many agencies. By the repeated and (I can find no other word) doggedly determined failure to not 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.

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Amanda Murr
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1st July 2025

Dear Amanda,

Thank you for submitting the Domestic Homicide Review (DHR) report (Doris) for Norfolk Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 4th June 2025. I apologise for the delay in responding to you.

The QA Panel commended this report for its touching opening tribute to Doris and for the strong family involvement. They found the review to be thorough and comprehensive, with clear efforts made to extract learning from a deeply distressing case. The action plan was also noted as detailed, with clear timeframes included.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published. **Areas for final development:**

- The QA Panel suggested that expanding acronyms on first use would improve accessibility and ensure the report is easily understood by a wider audience.

- Further anonymisation should be considered to protect the identities of the individuals referenced in the report. As it stands the nature of the case makes it relatively easy to identify those involved.

- The QA Panel noted the report is quite long and suggested that a more concise summary and streamlined content could improve readability and engagement.

- The report requires a thorough proofread prior to publication to address minor spelling and grammatical issues.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel