NORFOLK COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Into the death of Sofia

December 2020

Report Author

Gaynor Mears OBE, MA, BA (Hons), AASW, Dip SW

Report Completed: 4 December 2023

FAMILY MEMBER'S PORTRAIT & TRIBUTE TO SOFIA

Our mother was born in 1931 in the southern province of Skåne in Sweden and went to university in the university city of Lund. After graduating she continued her studies in Aberdeen, Scotland where she met our father. Later the family moved to Norwich and Sofia joined the faculty of Scandinavian Studies at the University of East Anglia (UEA) which had recently opened. She was offered the choice of a part-time or a full-time position but because she was raising 4 children, she chose part time. Life can be unfair, our mother worked as many hours and made an equal contribution as her full-time colleagues, even though she only received a part time salary. She also authored and co-authored various academic books. She was well ahead of her time, being both well-educated and a career woman long before this was considered normal.

During our childhood school holidays, we went touring by car through Scandinavia and stayed for many weeks on the sandy beaches of Yngsjö, where my mother had also spent her childhood holidays in her parent's summer house just 100 metres from the Baltic sea. We often made detours through Norway, Denmark and other European countries including Switzerland, and for example on one occasion we drove through East Germany, where going through an 'iron curtain' check point was quite intimidating. Our mother was avidly interested in the Vikings as this was part of her heritage and she used the Viking sagas as practice reading material for us children when we were young, reading by the fireplace burning pinewood logs and fir cones in the beach summer house. Many years later when reading Tolkien (The Hobbit and The Lord of the Rings), everything seemed very strangely familiar – people's names, place names, magic, and beliefs and even the runic scripts, because Tolkien was influenced by Norse mythology.

One time we were visiting a Viking rune stone which was well off the normal tourist route when another English couple turned up unexpectedly. They asked our mother to translate the tourist notice board into English, but to their surprise and astonishment, she went instead to the runic inscriptions and translated these directly into English; she had studied Old Norse at university, not many people can read and understand the old Viking languages as she could.

After retirement our mother continued to travel extensively, including Europe, the Far East, Asia, and South America. She loved her house, and especially her beloved garden, where she had lived for almost sixty years. As our mother's mobility reduced in her later years, she would often spend many hours reading books in her garden. She kept her teacher's mindset as old habits die hard and would often be reading a book with a red pencil in one hand, making corrections whenever necessary. She continued to read academic books until her last days.

---- o ----

One aspect of our mother's life that we are very proud of, is how much she was able to achieve in her career, despite having to overcome adversities in her life. Mum lived in a time where the female role was at home. It must have been very hard for her to reject those social norms, and instead pursue her passion for teaching and learning, leave Sweden, and have a career of her own. As a result of her many successes, she was invited to attend a number of Swedish embassy galas and events, where she loved meeting famous and interesting people. She truly was a career woman, before her time.

Mum was very committed, hardworking, fiercely proud of her family, frugal, and a little bit eccentric. She had a broad outlook on life and had an open mind to new experiences. She was a fearless adventurer of the world and was inexhaustibly curious. Mum was a dedicated friend; she held deep and long lasting friendships through her letter writing with people from all chapters of her life. More than anything, she was dedicated to learning, and was an extremely motivated woman.

Mum was incredibly proud of her children and grandchildren. She got to attend the wedding of her oldest grandchild in 2016 and she was looking forward to attending the wedding of her second oldest grandchild in June 2022. This was not to be. Her dearest wish was to be a Great Grandmother. She had so much to live for. She would have hated the fact that her family has now fallen apart and that her death was at the very hands of one of her beloved grandchildren.

However, her influence does continue today; every single one of her children has chosen to live abroad at some point in their lives, just as she did. Each one of her children are multilingual, just like she was. Her grandchildren too have all been brought up with an international life perspective and in particular, she would be proud of the strong females of her family. They have pursued academic study: they are women in medicine, women in law enforcement, women in architecture, women in science. They are the next generation of career women following in her footsteps.

The tragedy of her death will never leave us. The nature of mum's death does not help - being burnt alive while left alone with someone suffering a psychotic episode. She must have been terrified when she opened her bedroom door only to be blown over by a fireball of flames that burnt her face and hands. She lay on the floor of her bedroom unable to move until she eventually succumbed to the smoke. No one should die like that, and it is an image that is impossible to forget.

---- o ----

My mother was an incredible lady, who had dignity, humanity, faith, and purpose in life. She asked for little and gave much. She cared deeply for her family here in the UK and those in Sweden. She gave much to children's charities, education and those compromised by geopolitical conflict. She cared a great deal for those less fortunate and was always ready to help.

She leaves behind so many amazing memories, day to day mundane and often inconsequential recollections that hold great significance to those she was close to. She was an intellectual force in her younger years, a hard working independent lady who inspired responsibility and uncompromising integrity. She was not quite so good at driving and there is much discussion in regard to if she ever managed to make it to

3rd gear; driving shotgun with her was a noisy and bone-jarring affair. It was a sad day when due to her cognitive and visual deteriorations she had to give up her little blue car, a necessity but a loss and the first of many subtle steps from independence to dependence.

She was an incredible grandma, who was a constant presence and second parent in my daughter's life; always there to laugh, cry, and celebrate all the achievements and disappointments. She grounded my daughter's life with mutual love and respect. More often than not the pair of them could be found as a rather muddy duo in the depth of her much loved magical and somewhat overgrown garden. Endless hours were spent harvesting plums, on hands and knees scraping moss from time-old flagstones, collecting copious amounts of wind-blown leaves, running up and down the garden getting kinks out of the unruly hosepipe, digging up abundant amounts of new potatoes for potato and marmite sandwiches. There was a hedgehog who visited every morning for years, and a resident family of appreciative robins who appeared whenever digging was in progress. She respected nature and nature respected her. My daughter's academic studies and love of the natural world was embedded by her grandmother. Every Christmas they would spend much time constructing, consuming, and replenishing their Swedish Christmas Table full of readily accessible sweets and treats. Every New Year they would stay up till midnight waiting for the fireworks to dance around the living room singing Auld Lang Syne in a nod to the years spent as a young academic building her family in Edinburgh. Christmas was a special time with grandma, it is also the season in which we lost grandma, and there are no words to explain the trauma and violence of mum's passing. Sadly, she is now just a number on the annual Killed Women's list.

Mum was a lady of worth, with a wealth of compassion. Old age, vulnerabilities and faded aesthetics promoted bias assumptions that obscured the responsibilities of our Care and Protective services who had the power to consider, support, and help her. Inexcusably no one bothered to speak with her or attempted to understand her impossible situation. To us she was not just an old lady with failing health, she was a human being of comparable worth and as much right to autonomy and respect as any other member of society. In her time of need pleas for help were ignored, she became invisible in plain sight. Irrelevant. Inconsequential. She was left to fend for herself. Frightened, isolated, and abandoned she was consumed by smoke and flames and left to die in the living hell of her beloved home that should have been her sanctuary. A horrifying death. Refusing mum service driven support was and is an insurmountable shame intensifying the family tragedy and determining a shocking realisation of how worth is measured and assessed by those responsible to safeguard in our society. I have heard many excuses tied up with self-preserving legalese, but not one simple apology. Adversaries determined to silence their critics have ripped the family apart creating more destruction and suffering. Mum was worth so much more than this and should have been deserving of dignity in life as well as in death.

---- o ----

The Domestic Homicide Review Panel and the members of the Norfolk County Community Safety Partnership would like to offer their sincere condolences to Sofia's family members for the loss of their much loved mother and grandmother under such tragic circumstances.

The Panel is very aware that Sofia is not the only victim of the terrible crime that took her valuable life. Her children and grandchildren are also victims whose lives have been affected in numerous ways in addition to their grief. We acknowledge that this Review and other processes which have followed Sofia's death have also unintentionally caused anxiety, and we recognise that regrettably the Review has been unable to meet all the expectations of every family member.

Nothing can diminish the family's feelings of loss, but it is fervently hoped that the findings from this Review will go some way to meet the family's generous wish for learning to be gained which will prevent other families experiencing similar traumatic events.

The Review chair and Panel members strongly urge all services to act on the findings in this report, and for the government to act on the national recommendations.

Contents

Preface

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. The victim Sofia's death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance[1] 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,

1. Domestic Abuse Act 2021: Definition of "domestic abuse"[2]

(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.

(5) 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).

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised August 2016) Section 2(5)(1)
[2] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacte

DOMESTIC HOMICIDE REVIEW

1. Introduction:

1.1 This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Sofia[3] a resident of Norfolk prior to her death in December 2020. In addition to agency involvement the review will examine the past to identify relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether any barriers existed to accessing support. By taking an holistic approach the review seeks to identify solutions to make the future safer.

1.2 The circumstances leading to this review concern the setting of a fire in Sofia's home by her grandson Brennan[4] in which very sadly Sofia was killed. Brennan had experienced an episode of mental ill-health 6 months before the fatal fire which resulted in his treatment in hospital under the Mental Health Act. He had been away at university in the autumn of 2020 but had returned unexpectedly to Sofia's home. Shortly after his arrival he reportedly started acting aggressively towards his father following a dispute over a phone. His father was also living in the house as Sofia's carer due to her increasing frailty. Brennan's father called the Police on 999; however, no crime was identified to arrest him and no mental illness was apparent to officers. Covid restrictions prevented alternative accommodation being used. Brennan's father feeling fearful of his son left the house for his own home nearby. Soon after Brennan set a fire in the house and left the property. Tragically, Sofia was killed as a result of the fire before it was discovered. Brennan was found guilty of manslaughter due to diminished responsibility.

1.3 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides which meet the definition of domestic 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, and most importantly, what needs to change to reduce the risk of such tragedies happening in future. Reviews are not enquiries into how the victim died or who is culpable; that is a matter for coroner's and criminal courts to determine as appropriate, nor are they part of any disciplinary inquiry or process[5].

Timescales

1.4 Norfolk County Community Safety Partnership were notified of Sofia's death by the Police soon after the fatal fire, and a multi-agency Gold Group[6] meeting was convened on 13 January 2021. The Gold Group membership contained appropriate level representation from statutory agencies and senior representation from the voluntary sector specialist domestic abuse service in the county. At this meeting the Group could not all agree that the case met the criteria for a DHR.

1.5 On 7 April 2021 further information that should have been made available to the Gold Group emerged from an agency's records which had been omitted due to human error. A second Partnership Gold Group meeting was held on 27 April 2021, however, again there was no consensus that the criteria for a DHR were met. On 29 April 2021 the details were forwarded to the Home Office for guidance from the DHR Quality Assurance Panel. The Home Office confirmed Sofia's death met the criteria for a DHR on 7 May 2021, and in their view *"it would be pertinent to conduct a review in order to independently review the*

[3] A pseudonym chosen by her family.
[4] A pseudonym chosen by his father.
[5] Section 2 (10) Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. December 2016.
[6] The Gold Group is a Community Safety Partnership (CSP) standing partnership group chaired by the CSP chair which meets to determine if a death meets the criteria for a Domestic Homicide Review (DHR).

circumstances which led to this death and ensure lessons are learned". Recruitment of an independent chair and report author began at the end of May and the chair was appointed in August 2021.

1.6 The chair of this Review would like to highlight that this DHR is a clear case of an Adult Family Homicide defined as "*the killing of one or more family members by another family member where both victim and perpetrator are aged 16 or over. For example, where an adult kills their parent or grandparent*"[7]. Thus, the definition of domestic abuse as stated on page 1 of this report is met as is the criterion for a DHR to be undertaken. To avoid such unnecessary delays to future DHRs it would be helpful for all Gold Group members to ensure they are familiar with the legislation and Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews[8].

1.7 The Review was concluded on 4 December 2023. It was not possible to meet the 6 month statutory timeframe for the completion of DHRs due to the process discussed above and the conclusion of the criminal justice process. The perpetrator was found guilty of manslaughter in January 2022, but sentencing was delayed until October 2022 due to the treatment and diagnosis process required to inform sentencing. In addition, there were two violent assaults involving Brennan in prison which had to be investigated and considered as part of the criminal case. The criminal justice process also affected the reviewer's ability to interview family and friends. A further delay occurred as an official complaint had been made by a family member concerning the Police conduct in their handling of the case and their following of the Victim's Code**.** The Independent Office for Police Conduct (IOPC) inquiry caused significant delay in the provision of the Police Individual Management Review (IMR) report being available to the Review Panel. The Review has made a national level recommendation as a result of this delay.

Confidentiality:

1.8 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.

1.9 To protect the identity of the victim, perpetrator, and their family members the following pseudonyms chosen by family members have been used throughout this report.

The victim Sofia: aged 89 years at the time of her manslaughter.
The perpetrator Brennan (Sofia's grandson): aged 19 years at the time of the offence.

1.10 Sofia was of Swedish ethnicity.
Brennan was of dual heritage Thai/white British ethnicity.

Terms of reference of the Review :

1.11 **Terms of Reference for the 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;

[7] MMU2621-Briefing-paper-Adult-Family-Domestic-Homicide_V5.pdf (domestichomicide-halt.co.uk)
[8] DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

- 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.

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

The purpose of the Mental Health Homicide Review running concurrently with this DHR is:

- To understand the circumstances of Sofia's tragic death and identify any lessons that should be learned by NHS staff to strengthen mental health services; to reduce the risk that such an event could happen again.
- The Mental Health Homicide Review, whilst addressing its Terms of Reference agreed with NHS England, has also addressed the DHR specific terms of reference which are relevant to its remit viz a viz Mental Health Services.

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 mid-2017 when the perpetrator came to the United Kingdom to commence his A level education, up to December 2020. 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.

   All Agencies:

2. Was either the victim or the perpetrator assessed as an 'adult at risk' as defined by the Care Act 2014 which came into force on 1 April 2015? If not were the circumstances such that consideration should have been given to an assessment?

3. Did Sofia, or close family members, ever express unhappiness or concerns about the perpetrator being in her home to anyone involved in her care, and if so, what was done with the information or what action was taken?

4. Had the individual practitioners in contact with Sofia to provide care and support, or involved in decision making about safeguarding, undertaken the following training:

   a) Domestic abuse training (state duration and content of the training)
   b) Adult family 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) 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 elder abuse in a domestic abuse context. If not, identify the practitioner's gaps in their training needs?

5. What risk assessments did services in contact with the victim or perpetrator undertake in the course of their involvement? Including:

   a) Was the risk assessment fully informed by an assessment of the victim's home environment, the standard of care provided to her, and include consideration of the other occupants in her home including the perpetrator?

b) Was the risk assessment reviewed and updated in response to changing situations or information?
c) 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 cases.

6. What was the impact of Covid 19 and the restrictions put in place by the government in March 2020 on service provision and the ability of services to support vulnerable members of society such as Sofia?

7. Did the perpetrator's ethnicity or cultural heritage affect the following?

   a) Impact on how services were provided and if so, what steps were taken to mitigate this?
   b) How he interacted with services or how he may have made decisions?
   c) Were these factors taken into consideration in any assessments?

8. Although it is reported that the family carried out some clearing within Sofia's home after her fall in 2019 to deal with what was described as hoarding, is there any learning around hoarding and fire risks which are particularly relevant given the homicide occurred via arson? Had the clearing and decluttering carried out been maintained to ensure Sofia's continuing safety?

9. All Individual Management Reviews[9] (IMRs) to include analysis of whether questions asked in interviews or assessments were sufficiently probing and demonstrated professional curiosity to identify domestic abuse, or coercive and/or controlling behaviour towards the victim. This includes situations where interactions with parties reached the definition of domestic abuse.

10. Were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? Include caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.

11. Were the family made aware of the availability of a Carer's Assessment and relevant benefits such as Attendance Allowance to contribute to the support of caring for Sofia?

12. Given Sofia's diagnosis of cognitive impairment in 2017, and 2018 follow up assessment by a Consultant Psychiatrist from the Memory Assessment and Treatment Services regarding continuing memory problems, was her registered Lasting Power of Attorney (LPA) involved in all assessments and decisions, and if not, why not? GP IMR to include whether a follow up assessment or assessments of Sofia's cognitive impairment took place as planned after the 2018 assessment and the results of any further assessments.

13. Were the actions or information sharing by those involved with either Sofia or Brennan 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.

[9] Individual Management Review are reports provided to the Panel by each agency who had contact with the victim or perpetrator. They are tasked with investigating their agency's actions under the DHR Terms of Reference. They are confidential and remain the property of the individual agency.

Adult Social Care:

14. To analyse the safeguarding process and decision making following the receipt by Adult Social Care of the letter raising a family safeguarding concern on 18 June 2019. This to include:

    a) Were existing safeguarding procedures fully followed?
    b) Were other agencies and service providers contacted to share information regarding background history about the victim and perpetrator's situation, vulnerabilities affecting the victim and impact on her care needs, any previous concerns, and their views on the safeguarding concerns raised.
    c) What direct assessment did Adult Social Care staff themselves undertake to inform decision making?
    d) What risk assessment tool or checklist was undertaken?
    e) Why did Adult Social Care not make a home visit to speak to Sofia on her own to inform their assessment? Why did Adult Social Care not discuss the situation with Sofia's Lasting Power of Attorney (LPA)?
    f) Was the decision not to take the family's concerns further made with full and corroborated independent information?
    g) Are the current safeguarding policies and procedures fit for purpose to ensure the safety and wellbeing of similar vulnerable adults as Sofia?
    h) Does Section 42 of the Care Act 2014 require review and amendment to increase the safety and wellbeing of vulnerable adults and to assist professionals in their work to achieve this?

Mental Health Services:

15. What risk assessments were undertaken by Mental Health Services during their contact with the alleged perpetrator and:

    a) What was the risk assessment outcome of the perpetrator's 'risk to others'?
    b) Did he express any specific threats or animosity towards individuals or family members? If so, what was done with this information?
    c) Were risk assessments shared with family members?
    d) Did the service assess the perpetrators residential circumstances? This should include whether the service was aware that the perpetrator was living in the home of his vulnerable grandmother and was she consulted as part of the assessment process? If not, why not?
    e) Were family members made aware of how to manage the perpetrator's behaviour and any contingency plan for emergencies?
    f) What monitoring was put in place to ensure the perpetrator was complying with his medication? What alerts or actions were triggered when Brennan's father raise his concerns that he suspected Brennan was not taking his medication, due to the erratic content of Brennan's phone calls?
    g) Were Mental Health Services aware of the perpetrator's previous history and from whom was this obtained? If from the perpetrator were steps taken to verify the accuracy of the information?
    h) Given that substance misuse, including cannabis use by the perpetrator was a factor, was the impact on his mental health of cannabis and other illicit substances given sufficient weight when assessing risk to others, and was referral to a drug and alcohol service considered or made for the perpetrator?

16. Why were family members, other than Brennan's father, including Sofia's Lasting Power of Attorney, not made aware that Brennan had mental health issues, had been Sectioned for violent behaviour and was staying at his grandmother's house?

17. Following the perpetrator's move to the University of Manchester, was the transfer of information to relevant services in that area undertaken effectively and were there any barriers which affected the provision of ongoing mental health support to him.

18. When the perpetrator was discharged from hospital under Section 2 of the Mental Health Act 1983 in the summer of 2020, was his suitability for discharge effectively assessed? Was the location to which he was discharged assessed or considered? Were there any resource issues which influenced the discharge decision?

The Police:

19. When attending the incident between Brennan and his father on the night preceding the fatal fire were the officers fully informed enroute of the family situation, and did two of the officers recognise their previous involvement with the perpetrator in May 2020 which resulted in his detention under the Mental Health Act? If not, why not?

20. Did the officers recognise the incident as domestic abuse related and was a DASH[10] or other risk assessment undertaken? If so, what risk level was calculated and what decision was made as a result?

21. When attending the December 2020 incident were the police aware that a vulnerable elderly woman was resident in the property who might be at risk, and what steps were taken to speak to the victim herself to assure her safety and wellbeing, and to provide reassurance given the disturbance which had taken place between Brennan and his father? If not, why not?

22. Did the police consider making a vulnerable persons referral to Adult Social Care in light of Sofia's presence in her home at the time of officers attendance at incident?

23. What was the duration of the officers enquiries at Sofia's home in December 2020? Was sufficient time and open and probing questions used to explore Brennan's mental state, and on what basis did the police conclude that Brennan was not a threat to either his father or Sofia? This should include a review the body cam footage and transcript.

24. The perpetrator's father feels his concerns were not listen to by attending officers in December 2020. What did officers understand to be his concerns, if they were not clear what his concerns were what actions were taken to clarify his assessment of the situation which led to him calling the police via 999?

25. Was sufficient weight given to information provided to the police by the perpetrator's father given that the police should have been aware of the perpetrator's mental ill-health from their previous involvement with him in May 2020?

26. What assessment did the police make of Brennan's father's presenting disposition, his concerns about impending violence from Brennan, and did they understand that he felt his life was under threat hence his 999 call to the police for help?

27. Did officers make a contingency plan with Brennan's father before leaving the property in case his concerns escalated? If so, did this include evacuating the property if necessary, and was consideration given to involving out of hours support services such as Mental Health Services.

[10] DASH – Domestic Abuse, Stalking & Honour Based Violence risk an evidenced based assessment checklist used to assess the level of risk faced by victims of domestic abuse.

28. To provide an explanation for the perpetrator's father regarding why Brennan was not arrested or evicted from the house when he made this request when, in his opinion, he had provided compelling reasons (including fears of violence) to do so?

29. Was consideration given to the Covid pandemic restrictions in place at the time (people were prohibited from meeting those not in their "support bubble" inside. People could leave home to meet one person from outside their support bubble outdoors.) and that the perpetrator had breached these by leaving his accommodation in Manchester to go to his grandmother's home when she was in a vulnerable group due to health and age.

The University of Manchester

30. Confirm the timeline of Brennan's arrival and departure at the university, and whether Brennan informed the university that he was leaving.

31. Was the university aware of Brennan's mental health history prior to being contacted by his father? If not, why not? What is the process the university has in place to be made aware of any health vulnerabilities a student may have, and what support is in place for those who require additional support and did Brennan access available support?

32. Was any consideration given by the university student mental health, pastoral, or support services to request Brennan's registered GP visit him in his student room to undertake a mental health assessment as requested by his father?

33. In view of the Covid 19 related movement restrictions put in place by the university on students, was any special care given to students who were known, or who may be reasonably expected to be known, to be more vulnerable to adverse effects on their mental health by these restrictions?'

34. Did the university observe, or was it reported to any staff, that Brennan's behaviour was causing concern? What action did the university authorities take, and did this trigger any report or alert to the special needs department or to inform his next of kin?'

35. What follow up and monitoring of Brennan, if any, was undertaken when Brennan's father raised his concerns?

36. Does the university have a policy regarding the circumstances in which information can be shared with a parent or guardian about their adult child's mental wellbeing, and if so under what circumstances can this take place?

37. Did Brennan come to the attention of university security at any time?

The Manchester Medical Practice

38. Had the GP Practice received Brennan's medical notes from his previous GP, if so when were these received and were they examined to enable the practice to be aware of his mental health history and treatment?

39. Bearing in mind the impact of Covid-19 at the relevant time, was consideration given to inviting Brennan to a new patient assessment in light of his previous mental health history or an alternative consultation such as online or phone? If so, what was the outcome?

All Agencies involved in Assessing Mental Capacity as part of their duties:

40. Are the current procedures, assessment tools, and professionals' training for the assessment of Mental Capacity fit for purpose in assessing the continuum of diminishing levels of capacity from the onset of memory loss and how this affects a person's decision making abilities, through to the onset of clear incapacity to make decisions? If not considered fit for purpose what revisions can be recommended to make the process more effective and helpful for professionals to use in similar cases?

Fire & Rescue Service:

41. Had the Fire & Rescue Service provided any fire prevention advice to the victim or family members at any time regarding any safety measures for Sofia's home.

42. From the investigation into the causes of the fire address the following:

    a) was the electronic Nest surveillance and alert system for the fire alarm active at the time of the fire? If not, why not?
    b) why did smoke detectors and/or fire alarm measures not alert anyone to the presence of the fire?

43. Were there measures which could have prevented the damaging and fatal effects of the fire which were not present in the property?

Methodology:

1.12 The early part of the Review and the ensuing delays have been described in the Timescales section. Enquiries were made to establish if the DHR should be a joint DHR and Safeguarding Adult Review (SAR), however, the Panel were advised that the criteria for a SAR was not met. A total of 18 agencies were contacted to establish which had contact with Sofia, the victim, or Brennan the perpetrator. Eight agencies reported no contact. Ten agencies confirming contact were asked to secure their files and following the appointment of the chair/author the agencies provided a brief chronology of their contacts. The Review author produced a draft initial combined narrative chronology to inform the development of the Terms of Reference. Family members were consulted at an early stage on the draft Terms of Reference prior to the first Panel on 19 January 2022. Amendments were made at the Panel and the revised Terms referred back to family members when some minor amendments were made. The final Terms were emailed to Panel members. Agencies required to undertake an Individual Management Review (IMR) or reports were agreed and a date set for their submission post-trial.

1.13 To ameliorate the unfortunate delays in commencing this Review and the constraints of the criminal proceedings, the senior investigating officer agreed that following the guilty plea at court, the DHR Panel could progress with assessing Individual Management Reviews (IMRs) as only sentencing remained to conclude the criminal justice process. IMRs were assessed at the second DHR Panel on 8 June 2022; further points of clarification were raised during this process and these were addressed by IMR authors via email. A Mental Health Homicide Review commissioned by NHS England ran concurrently with the DHR and the independent author for that Review joined the DHR Panel. Interviews were curtailed at the request of the Police until after sentencing.

1.14 Following sentencing in the autumn of 2022 the chair wrote to two psychiatrists who provided reports for the court. The chair is grateful to consultant forensic psychiatrists Dr Toral Thomas and Dr Ian Cummings for their consent to access relevant information and their expert assessments for the court and for the trial judge's permission for their use by the DHR.

1.15 The chair undertook a telephone interview with the manager of the care company which provided the most recent occasional care to Sofia. Information from other care agency staff was accessed via their Police statements due to the length of time since they delivered care to Sofia, and some no longer worked for the agency.

1.16 Relevant research and policy documents have been reviewed and these are cited in footnotes when referenced. In addition, the chair was provided with 19 documents by the Adult Safeguarding lead relating to the safeguarding adults process.

1.17 The Panel's Fire Service representative facilitated an online meeting with the Review chair and the National Fire Chiefs Council lead on assistive technology and smoke detectors. This was very beneficial in formulating a response to issues arising from the fatal fire. The chair also liaised with the national accident prevention and home safety organisation RoSPA[11] concerning aspects of the smoke alarm system in use in the victim's home, providing anonymised details of the cause for concern and requesting they consider publicising the issues identified with privately purchased wi-fi home safety devices. Enquiries were also made concerning the working of the pendant alarm worn by Sofia with the local authority and the provider.

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

1.18 Sofia's adult children were informed in a letter by the Norfolk County Community Safety Partnership that a DHR would be taking place, and when the chair was appointed. The chair then wrote to introduce herself and explain the purpose of the Review. The letter included the Home Office DHR leaflet for family members, and a leaflet explaining the services of AAFDA[12]. One family member was supported by AAFDA, one by a member of the Victim Support Homicide Team, and Hundred Families[13] also provided support to the family.

1.19 The chair met with two family members who live in Norfolk after her appointment and held online meetings with two family members who lived in other parts of the country. She was accompanied by the Panel member representing Leeway Women's Aid. These initial meetings were limited to explaining the Review process due to the continuing criminal court proceedings. Discussions regarding composing and agreeing the Terms of Reference took place via email with the family. Regular updates were provided via email and further online meetings during the progress of the Review. The independent chair of the Mental Health Homicide Review also joined online meetings with family members. The chair attended some of the court hearings online including sentencing with the assistance of a family member and the Crown Court.

1.20 Contact was made with two of Sofia's close friends, one of whom contributed via telephone. The second of Sofia's friends had an introductory phone call with the chair, but then follow up letters remained unanswered. Family members and their advocates and supporters were provided with a draft of the report on which to comment and feedback was provided

[11] RoSPA is a not-for-profit organisation that has worked for more than 100 years to help people recognise and reduce their risk of accidents, at home, on the road, at work and at leisure.

[12] Advocacy After Domestic Abuse (AAFDA) https://aafda.org.uk/ - a charity specialising in expert and peer support to families who have experienced fatal domestic abuse including through major criminal justice processes such Domestic Homicide Reviews, Inquests, Mental Health Reviews, and Independent Office of Police Complaints Inquiries.

[13] Practical information for families affected by mental health homicides in Britain. hundredfamilies.org

via email, following which amendments or additions were made to the report. Three family members and their supporters attended the final Panel.

1.21 It would not be an exaggeration to say that Sofia's homicide has had a devastating effect on her family, however, they have generously played an active part in the DHR and the chair and Panel members are most grateful for their assistance and input. The chair also appreciates the support offered to the family by their advocates and supporters.

1.22 Following advice from Brennan's consultant psychiatrist that he was well enough to be interviewed, and liaison with his supervising psychiatric nurse, the chair wrote to Brennan in November 2022 inviting him to contribute to the Review. The letter was sent in English and Thai with a copy to his supervising psychiatric nurse and psychiatrist. Unfortunately, although Brennan at first agreed to contribute, he then changed his mind and declined to take part. A further attempt was made in March 2023, but his supervising nurse reported his response remained the same. No reason was able to be given for Brennan's decision.

1.23 The chair had three initial email contacts with Brennan's mother in Thailand prior to the trial explaining the Review process. A series of questions which were translated into Thai were emailed to her in January 2023. A further email seeking assurance that the emailed questions had been received was sent at the start of March 2023, however no reply was received. Further attempts to contact her have been unsuccessful.

Contributors to the Review:

1.24 The agencies contributing to the Review and the nature of their contributions shown in the table below:

Name of Agency	Chronology	IMR	Report
1.Norfolk Constabulary	√	√	
2.Norfolk Adult Social Care	√	√	
3.Primary Care/GP Practice for the perpetrator	√	√	
4.Primary Care/GP Practice for the victim	√	√	
5.Norfolk & Suffolk Foundation NHS Trust (Mental Health Services)	√	√	
6.Norfolk Community Health & Care NHS Trust (O.T. Physiotherapy)	√	√	
7. University of Manchester	√	√	
8. GP Practice in Manchester	√	√	
9. Norfolk Fire & Rescue Service	√	√	
10.Private Care Services	√		√
11.School Attended by Perpetrator	√		√
12. A Norfolk Local Authority Housing Department	√		√
13.Anne Richardson Consulting Ltd, Independent Report Author Mental Health Homicide Review for NHS England			√

1.25 The authors of agency IMRs were independent of the case; they had no management responsibilities for the frontline staff who provided services, nor did they have personal

contact with Sofia or Brennan. IMR authors accessed their service records and policies, and where possible interviews with staff involved took place: When not possible this was due to staff retirement or having left the organisation.

1.26 The IMRs were assessed at a DHR Panel designated for that purpose. Where further clarification or additional information was required, this was requested and provided. Panel members also provided follow-up observations or comments to the chair following this Panel. The Mental Health Homicide Review report was provided at a later stage following an extensive analysis of records, policies, and interviews with mental health professionals involved in the perpetrator's care. As previously mentioned in the Timescales section, the Police IMR for the Panel was not received until March 2023 when it was assessed at a DHR Panel that month.

The Review Panel Members:

Name	Agency	Job Title
Gaynor Mears	Gaynor Mears Consultancy	Independent DHR Chair/Author
Anne Richardson	Anne Richardson Consulting Ltd	Independent Mental Health Homicide Review Author
Amanda Murr	Office of the Police & Crime Commissioner for Norfolk (OPCCN)	Head of Community Safety & Violence Reduction
Liam Bannon	OPCCN	Community Safety Manager
Tracy Stevens	OPCCN	Community Safety Support Officer
Mark Joyce	Norfolk Constabulary	Detective Chief Inspector
Dr Simon Merrywest	University of Manchester	Director for Student Experience
Dr Mithra Prabhu	GP Practice for the victim	General Practitioner
Gary Woodward	Norfolk and Waveney Integrated Care Board (formerly CCG)	Adult Safeguarding Lead Nurse
Sarah Shorten	Norfolk and Waveney Integrated Care Board	Deputy Safeguarding Nurse
Dr Maria Karretti	Norfolk and Waveney Integrated Care Board	Named GP for Safeguarding Adults
Becky Booth	Norfolk Safeguarding Adults Board	Deputy Manager, Norfolk Safeguarding Adults Board
Sonja Chilvers	Norfolk & Waveney MIND	Chief Operating Officer
Luke Adcock	The Matthew Project (drug & alcohol recovery charity)	Practitioner Manager City/South Team & Lead Affected Others
Craig Chalmers and or Helen Thacker	Adult Social Care Norfolk County Council	Director of Community Social Work Head of Service Safeguarding
Margaret Hill	NIDAS/Leeway Women's Aid	Community Services Manager
Jo Willingham	Age UK Norwich	Information, Advice, & Welfare Manager
Saranna Burgess	Norfolk & Suffolk NHS Foundation Trust (Mental Health Services)	Director for Patient Safety & Quality, Patient Safety Specialist
Anthony White then Emyr Wyn Gough	Norfolk Fire & Rescue Services	Head of Prevention, Protection & Emergency Planning
Suzannah Armstrong-Cobb	Office of the Police & Crime Commissioner for Norfolk	Communications Officer
1st Panel Only - Briefing for Panel		

DI Christopher Burgess	Norfolk Constabulary	Senior Investigating Officer briefing on incident and initial court proceedings
DCI Stuart Chapman[14]	Norfolk Constabulary	Inspector – Investigations
Gregor Preston	Norfolk Fire & Rescue Services	Head of Prevention, Protection & Emergency Planning
Claire Farrelly[15]	Norfolk Children's Services	Advisor, Safeguarding Education Quality Assurance & Regulation
Louise Honor	Manchester Health and Care Commissioning (for GP Practice)	Designated Nurse for Safeguarding Adults

1.27 The Review Panel was made up of senior level representatives from agencies involved in addition to other strategic level bodies such as the county's Safeguarding Board and Integrated Care Board, formerly the Care Commissioning Group[16]. The Panel also had the benefit of independent external contributions from specialist domestic abuse, mental health, substance misuse, and older people's services. They had no management responsibilities for staff who had contact with Sofia or Brennan, nor did they have contact with them.

1.28 The Panel met 8 times on the following dates: 19 January 2022, 8 June 2022, 1 November 2022,10 January 2023, 14 March 2023, 30 May 2023, 28 September 2023, and 22 November 2023.

Author of the DHR Overview Report:

1.29 The chair and report author for this Review is independent DHR chair and author Gaynor Mears OBE. 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 variety of experiences required for the role. She is independent of, and has no connection with, any agencies in Norfolk. Gaynor Mears has previously undertaken DHRs for Norfolk County Community Safety Partnership the last of which was completed in 2020. Full details of her professional background can be found at Appendix 1.

Parallel Reviews:

1.30 A coroner's inquest was opened and adjourned. The coroner was informed a DHR was commissioned by the Norfolk County Community Safety Partnership and they were updated by the chair on progress. Following the conclusion of criminal proceedings, the inquest planned to resume when the DHR was completed and available to the Coroner. The Home Office was consulted and consent was given to share the final draft of the Review with the Coroner for their information only to assist in planning the inquest.

1.31 Due to Mental Health Service's involvement with the perpetrator a Serious Incident Review was commissioned by the Mental Health Trust.

1.32 Following the first Panel NHS England decided the case met the criteria for a Mental Health Homicide Review and this ran alongside and contributed to the DHR. The independent author of the Mental Health Homicide Review joined the DHR Panel membership and there was regular liaison between the author and the DHR chair in addition to joint online meetings with Sofia's family.

[14] DCI Stuart Chapman was originally to sit on the Panel as the Police representative, however, after the first Panel he raise a possible conflict of interest with the chair as he was part of the initial investigating team. It was agreed that he would be replaced by an officer unconnected with the case.

[15] Proportionate with the historical nature of the education chronology Claire Farrelly provided information and updates on actions from the first Panel to the chair for inclusion in the report outside of Panel.

[16] The CCG became the Integrated Care Board on 1 July 2022 during the course of this Review.

1.33 Norfolk Constabulary Professional Standards Department completed a "Death or Serious Injury following Police Contact Investigation" in April 2021. Due to the ongoing criminal proceedings and a subsequent complaint made by a family member this report could not be submitted to the Independent Office for Police Conduct (IPOC) until late October 2022. It was not until 22 February 2023 that the IOPC confirmed their review was completed.

Equality and Diversity:

1.34 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. This section also examines any diversity issues which may have an impact or result in barriers to the victim or perpetrator accessing support. The following are relevant to consider for this Review:

Sofia:

1.35 **Age:** At the time of her death by manslaughter Sofia was 89 years old, therefore she was an older member of Norfolk's population. The 2021 census shows the county has a higher proportion of over 64 year olds (24.4%) compared to the England percentage of 18.4%[17]. This higher population of older people carries through the age ranges up to the 90 years plus age range. Inevitably this has implications for service provision and resources in the county as well as for individuals themselves. This will be mentioned again in the Analysis section concerning resources.

1.36 The charity Hourglass[18] points out older victims' experiences often differ to those of younger people, due to a variety of social, cultural, and physical factors that require attention. These can present barriers to older people reporting abuse or allowing others to report on their behalf. Hourglass practice and research identify these specific issues affecting older people as:

- For older victims, family members rather than intimate partners are most often the perpetrators of domestic abuse.
- Older women often feel expected to protect the family unit by staying with the abuser, and may fear losing relationships with adult children, family, and friends.
- For many older victims, abuse may become normalised and accepted, which can create barriers to getting help and support.
- Older victims may experience a decline in physical and cognitive health and become dependent on their abuser for support.

[17] ONS data 2021 Population - UTLA | Norfolk | InstantAtlas Reports (norfolkinsight.org.uk)
[18] Hourglass is a UK charity focused on the abuse and neglect of older people. It campaigns and provides a free-to-call helpline for older men, women and their families suffering from the five forms of abuse: physical, psychological, financial, sexual or neglect, including domestic abuse. Domestic abuse | Hourglass (wearehourglass.org)

- In some cases, older victims may also provide a caring role for their abuser which also impacts on their willingness to leave an abusive relationship.

- Ageist media and political campaigns against domestic abuse that predominantly focus on young women and children erasing the voices of older victims can contribute to barriers for older people reporting abuse and seeking help.

It must be noted that agencies had no direct evidence that there was an abuser or anyone who would cause Sofia harm in her home until after the fatal incident as no formal enquiries were made. Brennan's presence in the house was unknown to Adult Social Care, and other agencies did not assess risk to Sofia. Further discussion will take place in the analysis section of this report. The points above are highlighted here to increase learning and raise awareness of matters to consider when developing procedures and undertaking assessments involving older age adults.

1.37 Recent data indicates that older age has become relevant when considering risk of domestic homicide. 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 (18%), the next highest were aged 30-35yrs at 13%[19]. This highlights the vital importance that all agencies are trained to recognise older people, especially older women, can be victims of domestic abuse and homicide. It is essential to ensure older victims have equality of service provision to reduce the barriers which can inhibit older women's access to specialist support.

1.38 Also, of relevance concerning age; research indicates that during the first year of the Covid pandemic restrictions there was an increase in the proportion of older (65+) victims of adult family abuse homicide from 35% to 43%[20]. Very sadly, Sofia's manslaughter by her grandson was one of these cases.

1.39 **Sex:** Whether intimate partner abuse or adult family abuse, women are at significantly higher risk of domestic abuse and this level of risk continues into later life. For year ending March 2022, the Crime Survey for England and Wales estimated that 1.7 million women and 699,000 men aged 16 years and over experienced domestic abuse in the previous year[21]. The Home Office homicide index reveals between March 2018 and March 2021 76% of domestic homicide victims were women[22].

1.40 Older people frequently face additional barriers to accessing support services. Abuse may be recorded as 'elder abuse' and not recognised as 'domestic abuse' due to a lack of understanding among professionals, and because the perpetrator is not identified as a partner or family member, thus coming into the definition of domestic abuse[23]. An older person may not recognise domestic abuse, be fearful of leaving their home and uncertain of what might await them if they do. Older people have additional needs which may not always be able to be met by available services. It is also right to acknowledge that ageist stereotypes can exist which may impact on how older adults are perceived, whether unconscious bias or not.

1.41 Sofia's manslaughter can be classified as parricide, the killing of a parent or grandparent. This is the most common form of adult family homicide, and this too is a gendered crime;

[19] Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk)

[20] K. Hoeger et al 'Domestic Homicide Project Spotlight Briefing #2:Older Victims'. Vulnerability Knowledge & Practice. February 2022. Domestic Homicide Project - Older Victims Feb 2022 AC (vkpp.org.uk)

[21] Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk)

[22] Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk)

[23] Domestic abuse: more needs to be done to support older people | Discover | Age UK

research indicates that perpetrators are more likely to be the son or grandson of the victim who is usually female[24].

1.42 Here we also need to consider the intersection of age and sex. As Bowes (2019) points out "intersectionality stresses the importance of the interwoven nature of different categories such as race, class and gender, and how they mutually strengthen or weaken each other"[25]. To age and sex, it is appropriate to add class as a consideration. Sofia was a highly educated professional woman before her retirement who lived in an affluent area of the county. She was very independent and unfamiliar with using statutory services as were her family members. This lack of familiarisation with those services, in addition to having a strong sense of independence, may have formed a barrier to Sofia accessing social care services. As will be seen in the analysis section of this report, whilst discrimination or a lack of equal treatment was not intended or identified as such, Sofia was, as an older woman, completely overlooked by some services.

1.43 **Disability:** 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. 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[26]. Although Sofia was becoming increasingly frail due to her age and following her fall, she required a period of 24 hour live in care to regain a degree of improved mobility, her mobility appears not to have been sufficient to use the term disability when referring to her; she did not require a wheelchair for example, and no agency assessments used this term, although no recent assessment had taken place in the months before her manslaughter. The manager of the care service who visited her on a number of occasions described how Sofia would come to the door to let him in and she walked around the house unaided even though a walking frame was available for her to use. The Review chair has the distinct impression from information provided that Sofia's independent spirit would have seen her be dismissive, even offended, by any suggestion that she had a disability. However, Sofia was frail due to her age and her ability to protect herself from harm would have been significantly impacted by her physical frailty.

1.44 Following a fall in 2016, and another in 2019 Sofia had intermittent contact with various community health services. She also had reviews at her local GP practice and accessed routine seasonal vaccinations. There is no evidence that services with which she came into contact discriminated against Sofia in the provision of these services which were appropriate for her age and her health condition at that time. Her age related cognitive impairment would also not have been sufficiently debilitating to imply she had a mental disability. However, a family member is of the view that Sofia's increasing cognitive impairment made her vulnerable to suggestion and easily coerced or controlled.

1.45 **Religion:** Sofia was a practising Christian who would attend her local church, latterly with the help of her eldest son once she recovered from a fall. Her youngest son informed the chair that he never knew his mother to tell a lie. She lived the values of her faith. This is of relevance, for had services ever spoken to Sofia herself with any degree of professional curiosity she would have undoubtedly been open and truthful in her answers and more could have been discovered about her household.

[24]Bows H, 'Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK', *The British Journal of Social Work*, Volume 49, Issue 5, July 2019, Pages 1234–1253, https://doi.org/10.1093/bjsw/bcy108

[25] Ibid

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

Brennan:

1.46 **Disability:** As explained in paragraph 1.42 above, the Act definition of disability, either regarding physical or mental health reasons, means Brennan's episodes of mental illness prior to the fatal fire, would not consider his condition to meet the definition of a disability.

1.47 **Race Including Ethnic or National Origins:** Brennan was born and brought up in Thailand. His mother was Thai, his father white British. He came to the UK at the age of 15yrs, therefore his formative years were spent in Thailand making his ethnicity and culture relevant for consideration.

1.48 Information taken as part of his history reported he was bullied at school in Thailand due to his mixed heritage. Information obtained from his school in England where he studied in the sixth form reported no such adverse experiences with respect to bullying or racism. The Review has been unable to corroborate his history or establish the impact of his early school experiences, therefore it is not possible to judge whether there were adverse childhood experiences which might need to be taken into consideration.

1.49 Brennan's English was good and checks established that an interpreter was not required for assessments or in court for his trial. This is also evidenced by the fact that he was successful in his A level examinations and the entrance requirements for university. A psychiatric nurse at the university who spoke with Brennan on the phone was not of British ethnicity and was cognisant of the needs of international students, in addition they were knowledgeable about various cultures and did not believe any cultural barriers affected their dealings with Brennan.

1.50 Although Thailand has a number of psychiatric facilities both separate and within mainstream hospitals and has done so for many years, there remains a degree of stigmatisation of mental illness among the public which research suggests is often the result of socialization such as culture and media exposure, for example people who are experiencing mental disorders are portrayed negatively in the media making it more likely they will feel ashamed of their illnesses[27]. This research undertaken with students found they felt uncomfortable discussing their mental health with family members, especially their parents, due to the students' belief that their parents' generation was not educated about mental health issues and was more likely to respond with negative comments. This finding was the same for students with a Thai or international background. Whether this formed a barrier to Brennan discussing his mental health when his father was present at appointments we cannot say conclusively as Brennan declined to take part in this Review. However, as became clear during the Review, Brennan was regularly found to be difficult to communicate with even when his father was not present.

1.51 The Review found no evidence that Brennan was discriminated against under any of the Equality Act subject areas. Although the Covid pandemic restrictions in place at the time impacted his life at university, his access to services was equal to any other person of his age and with similar health needs.

Dissemination:

1.52 The following will receive a copy of this Review:

- Family Members

[27] Pitakchinnapong, N. and Rhein, D., 2019. Exploration of the causation of stigmatization of mental illness in Thailand: perceptions of Thai university students. *Human Behavior Development and Society*, *20*(2), pp.7-19. (PDF) Exploration of the Causation of Stigmatization of Mental Illness in Thailand: Perceptions of Thai University Students (researchgate.net)

- All agencies on the DHR Panel and their chief officers.
- All services contributing to the DHR and their chief officers.
- Members of the Norfolk County Community Safety Partnership
- Police & Crime Commissioner for Norfolk
- Members of Norfolk Safeguarding Adults Board
- Department of Health & Social Care
- The Home Office
- The Domestic Abuse Commissioner for England & Wales
- The Chief Social Worker
- Head of Investigations, NHS England (Midlands and East Region)
- Independent Office for Police Conduct
- National Probation Service, Brennan's supervising Manager.
- Brennan's supervising Psychiatrist

2. Background Information (The Facts):

2.1 The victim Sofia lived in her own home for 57 years in the county of Norfolk and it was here that she lost her life as a result of an act of arson committed by her grandson. Sofia had become less mobile since a fall in 2019 in which she suffered a broken arm requiring treatment in Accident & Emergency of the local hospital. Following a period of recuperation of 3 to 4 weeks with her daughter, Sofia returned to her own home with the eldest of her three sons moving in to care for her along with time limited visits from First Response[28] carers. When Sofia's mobility improved carers were no longer commissioned unless Sofia's eldest son had to travel abroad for work, when daily carer visits took place.

2.2 The perpetrator Brennan, the son of Sofia's eldest son, came to the United Kingdom as a teenager from Thailand in 2017 to complete his education, he and Sofia had not had direct contact since he was a very small child. As a result of the geographical distance and the passing years they were unfamiliar with each other. Brennan was an occasional occupant at Sofia's home when not at university and he too was present in the house at the time of the fatal fire. Brennan was known to Mental Health Services having had an episode of mental illness in May 2020 whilst staying at Sofia's home during which he tried to force entry into a neighbour's house and he assaulted his father. He received treatment under Section 2 of the Mental Health Act 1983. He was diagnosed with acute and transient psychotic disorder and mental and behavioural disorder due to the use of cannabinoids. He was discharged on 18 June 2020 to the Mental Health Trust's Early Intervention Team[29] with medication. He left Norfolk for university in September 2020 having declined onward referral to services in his new location.

2.3 Brennan returned unexpectedly from university in early December 2020. A dispute ensued with his father who became concerned about his safety and called the Police on 999. After speaking separately to Brennan and his father officers were unable to identify an arrestable offence. Brennan's father was advised about alternative accommodation the next morning for his son before officers left. Sofia was not seen or spoken to. Still fearful Brennan's father left the house for his own home. A short time later Brennan lit a fire in the cupboard under the stairs, placed a chair in front of the door, and left the house. Alarms went off at 04:50hrs. The fire was discovered and reported by a member of the public at 06:41hrs. Sadly, Sofia died. Cause of death was given as due to smoke inhalation; Sofia also suffered burns to her hands, arms, and face.

[28] Norfolk First Response provides a short term support service to assist recouperation.

[29] The Early Intervention in Psychosis Service supports people between the ages of 14 and 65 in Norfolk and Waveney who are experiencing symptoms of a first episode of psychosis. This service supports people for up to a three-year period and provides intervention to reduce the impact of the symptoms and support social recovery.

2.4 Brennan returned to the house later, was arrested, and charged with murder and arson. He was found unfit to interview and held under the Mental Health Act until trial. In the Autumn of 2021 Brennan pleaded of guilty to manslaughter by reason of diminished responsibility and arson being reckless as to whether life would be endangered. Following psychiatric assessments this plea was accepted. He was sentenced to a Section 37 Hospital Order with Section 41 Restriction Order[30] under the Mental Health Act 1983 in October 2022.

2.5 In his summing up when sentencing the Judge's *statement included "The symptoms of your mental disorder in December 2020 were exacerbated by your voluntarily abusing drugs and choosing to disengage from the community mental health services that were readily available….. You had been told by doctors in summer 2020 what to do to avoid a relapse into drug-induced psychosis and you ignored that advice. Such deliberate actions heighten the level of responsibility you retained for this unlawful killing"*.

3. Chronology:

Background for Context:

Sofia:

3. 1 To gain a picture of Sofia's character, health, and the aspects which affected her day to day life in the years leading up to the timeframe under detailed examination the following background is provided.

3. 2 Sofia was retired from a long and successful academic career; she was a respected author in her specialist field. She came to the UK in 1954 and studied at St Andrews University in Scotland where she met her English husband from whom she was later divorced. Sofia had four adult children; her daughter and her eldest son who had returned to the UK having worked abroad for many years lived nearby, and two sons lived elsewhere in England. She was registered with the same GP practice since 1963 and had a diagnosis of asthma, high blood pressure, and osteoporosis. Sofia had an MRI in 2019 which confirmed this had deteriorated and there was marked crumbling of her lower spine in addition to other conditions for which she received treatment and regular reviews. Morphine patches helped to control the back pain Sofia experienced.

3. 3 On 20 March 2009 Sofia's GP Practice recorded information from a solicitor concerning a living will for Sofia. It included a request for Sofia's daughter and her third son to be contacted and involved in making decisions about her medical care on her behalf, and for them to be consulted about and involved in any decision if her life was in danger. This was followed on 2 July 2009 with an entry on Sofia's medical notes for Lasting Power of Attorney for personal welfare. To whom this applied was not recorded on the GP chronology, but Sofia's daughter informed the chair that she had this Power of Attorney (LPA) along with Sofia's solicitor, Sofia's youngest son was an alternative LPA. The following year, on 14 July 2010, Sofia had a GP appointment during which her notes record she was "stressed about family problems". There are no details recorded to elaborate or indicate what 'family problems' were causing Sofia such stress, or any advice and support offered.

3. 4 Sofia was treated at the Norfolk & Norwich Hospital A & E Department on 19 February 2013 for a laceration to her elbow which required 13 sutures. There is no recording explaining how she sustained this injury. The next record notes concerns raised in a call to NHS 111 on 6 December 2016 by Sofia's daughter stating her mother was not accepting help and would not discuss health care with her. Sofia was reported to be very frail, eating

[30] A Section 41 Restriction Order requires that the decision about release from a secure hospital is authorised by the Secretary of State. Any breach of supervision following release can result in the person be recalled into custody. What is a section 37/41? - Mind

out of date food, not washing, and had no clean clothes. Her daughter explained to the chair that her mother was very independent and happy to live with the support of her daughter and granddaughter attending to her needs, regularly providing company, transport, and meals as needed. Sofia had an established support network but she had a great fear of being put in a care home. This call also arose as Sofia had told her youngest son she had had a stroke. This was not correct but it set in motion her referral for cognitive assessments. Sofia's daughter was advised to follow up with Sofia's GP and Social Services.

3. 5 Later that morning (6 December 2016), Sofia was seen by GP2 following a fall the day before. She was offered Social Services input but declined; Sofia said she was afraid of not being found if she were to collapse and die but was happy with her family taking care of her. Notes from the visit are given here to give Sofia's voice. The notes record:

> "She [Sofia] was very off balance, (normal body temperature). Sofia said she had taken all anti-biotics; her granddaughter reminded her, but she had missed her blood pressure pills. Following examination, it was recorded: Sofia seemed very anxious. Mentally alert. Spending a lot of time in bed. Says is eating - but Out of Hours call report- raises concerns. Plan: falls assessment clinic- urgent. Refusing SS/ care/ swift/ ' leave me to sleep for 2 more days and I'll be fine' she says- has been very drowsy, slightly more confused not managing herself for past 2-3 weeks, occasionally forgetting medications. Poor intake- dehydration. Seems to understand that she is ill- states afraid to not be found if she were to collapse and die – clearly states – doesn't want anyone else in her house- only family to take care - offered if she would like me to speak to her daughter about this - refused. But clearly seemed reluctant to get daughter involved - either - but still says 'my granddaughter (17yrs) and daughter will take care of me'. Mixed messages from her. Reluctant but agreed to fall clinic ref - will ask for transport. Asked about Out of Hours call concerns about out of date food - says she will get rid of it - but couldn't then explain what she would eat and how she would manage to cook?? However, as of today- has mental capacity to consent."

3. 6 The planned review in 2-3 weeks took place on 21 December 2016; Sofia was feeling better, and an urgent referral to the falls clinic was made. She was seen at home by a consultant psychiatrist from the Memory Assessment and Treatment Services on 27 February 2017 regarding memory problems. Information was given regarding a pendant alarm for Sofa and she was discharged from the memory clinic.

3. 7 On 30 January 2017 Sofia was seen in a falls clinic by consultant physician 1, Older People's Medicine. She was reticent to discuss falls, thought to be due to a decline in her memory and fear of losing her independence if she revealed information. Evidence of poor medication compliance and drop in blood pressure on standing was identified. Medication via Dossett box[31] was recommended. Blood tests showed low iron levels and iron supplements were advised. A CT scan of the brain was requested. Sofia was seen again by GP2 on 28 February 2017 and was referred to a memory clinic. It is recorded "Family seems very supportive." Sofia stated she was selling her car for safety reasons. A month later Sofia had an annual hypertension review.

3. 8 Sofia was assessed by a psychiatrist at the Memory Assessment and Treatment Services on 18 April 2017. Mild short term memory changes were identified consistent with age appropriate involutional changes[32]. Diagnosis: mild cognitive impairment. A review in 6-8 months was planned and a referral to the Movement and Disorder Clinic offered due to worsening tremor in her hands. On the 24 July GP3 had a discussion with Sofia regarding the psychiatrist's diagnosis. It was confirmed that she lived alone but she felt she was

[31] Boxes with small compartments that clearly show which pills need to be taken daily at what time of day.
[32] The shrinkage of an organ in old age or when inactive.

managing well; she declined further help and was offered a pendant alarm which would enable her to connect to a 24hr monitoring service if she required help, but there is no evidence to confirm that Sofia took this further. Around this time a 'Do Not Attempt Resuscitation' form was completed with Sofia. Her medical notes state "patient very clear about it".

3. 9 Sofia was seen as very independent, and she did not want any help at home; she said she had a daughter who is a health professional, and her sons lived overseas. The following month Sofia had an annual asthma review.

Brennan:

3. 10 The perpetrator Brennan is the son of Sofia's eldest son from his first marriage. Brennan's mother and sister live in Thailand where he was brought up. From history taken during mental health assessments it is believed Brennan's parents separated when he was approximately 6 years old. It is understood that Brennan attended a private school in Thailand; he reported being bullied at school due to his mixed heritage. When Brennan was 12 or 13 years old he would lock himself in his room all day playing video games; he expected food to be taken to his room, and he would become angry if people interrupted or came into his room.

3. 11 There is information from assessments and Brennan's father that he experienced mental ill-health in Thailand aged approximately 14-15years. He was violent towards his mother and sister and there was an incident where he shot a `BB' pellet gun at his mother. He caused a significant amount of damage and expense by trashing his mother's apartment, writing various "demands" on the wallpaper of the home e.g., demanding certain food, and cutting up her clothes. Brennan was admitted to a facility in Thailand for a brief period for `gaming addiction' and he reported that this was when he first started using cannabis products (`gummies') bought online. Enquiries of Thai Police made by Norfolk Constabulary have not elicited further details, and Mental Health Services have been unable to corroborate this information with Brennan's mother as she has no notes from services in Thailand. Had the involvement of Community Mental Health Services with Brennan been of a longer duration, the Panel understands further contact would have been made with his mother via an interpreter to inform a longer term plan.

CHRONOLOGY FROM BRENNAN'S ARRIVAL IN THE UK 2017

3. 12 Brennan commenced 6th form education in September 2017 as a boarder at a state sector school in Norfolk arranged by his father. He was driven to the school by Sofia's granddaughter, his cousin. She collected him a week later for a family meal at her mother's home and returned him to school afterwards. Although invited to further meals, including at Christmas, Brennan did not attend.

3. 13 School reports of October and November 2017 recorded Brennan's progress as 'good and outstanding'. Whilst at the school, he was registered with a local GP practice. The only record of Brennan's attendance at the GP practice was on 19 January 2018 when he was seen with a painful arm recorded as happening playing basketball. He was referred for an x-ray, where a fractured left forearm was diagnosed and followed up by Orthopaedics. A school nurse recorded that Brennan attended with a painful arm on 24 January 2018, but he was vague about what had happened. He claimed to have visited the medical centre before but there was no record of this. He may have been referring to a GP appointment, but it would appear that no update had been given to the school who would have been acting in 'loco parentis' during term time as Brennan was a boarder.

3. 14 On 31 January 2018 a teacher raised concern about Brennan being listless. After a good start he appeared to be slightly disengaged and apart from the group. Another student said sleep was an issue. The following month on 25 February Brennan was due to have a follow up orthopaedic appointment. He had no one to go with him but did not want the

school to contact his family, nor did he want to travel by bus/taxi himself. Brennan said he would cancel the appointment and rearrange for the holidays. There appears to have been no sensitivity to the fact that this was only Brennan's second term at the school since joining from Thailand. Perhaps had the school nurse accompanied him he may have kept the appointment. There is no record that he did rearrange the appointment.

3. 15 During half term in February 2018 school records show Brennan spent this at Sofia's home. Although not exactly sure of the date but believed to be around this time, Sofia's daughter and one of her younger sons recall an incident in which their mother had come to her daughter's home in a distressed state citing Brennan's behaviour. He was opening windows causing a draft, smoking, and blowing smoke in her face. Sofia's daughter phoned her younger brother for help asking that he contact Brennan's father to remove Brennan to his care and for him not to live or be unsupervised in Sofia's home in future. Following this Brennan was not supposed to stay at Sofia's home. The family thought he was staying at his father's home nearby.

3. 16 During the summer term of his first year Brennan was observed to be a talented student capable of A grades, but his focus had deteriorated except in physics. There were also concerns about sleeping, being up late gaming, and falling asleep in lessons. His end of year report was good and outstanding. It is believed Brennan spent the summer holiday in Thailand. He returned to school for the Autumn Term in September 2018.

3. 17 School records show Sofia named as Brennan's guardian in the UK along with her home address. During his time at the school records show during exeats and holidays Brennan resided in the following locations:

Year 1: Brennan would often stay at College over the weekends.

- 19 Jan 2018 (exeat weekend) stayed at College.
- 9 Feb 2018 (half term) stayed at Sofia's address.
- 9 March 2018 (exeat weekend) stayed at College.
- 23 March (end of term) stayed at Sofia's address.
- 4 May 2018 (exeat weekend) stayed at College.
- 25 May 2018 (half term) - stayed at Sofia's address.
- 22 June 2018 (exeat weekend) - stayed at Sofia's address.
- 6 July 2018 (end of term) - travelled to Thailand.

3. 18 School records record Brennan resided in the following locations in his second year: he spent the October half term with a host family in Norwich and returned to Thailand for the Christmas holidays.

Year 13:

- 21-23 Sept 2018 (exeat weekend) stayed at College.
- 16-18 Nov 2018 (exeat weekend) stayed at College.
- Dec 2018 Brennan's mother emailed to say that he would be going to Thailand for the Christmas holidays and would be in her care. Left College on 13 Dec 2018 and returned on 8 Jan 2019.
- 25-27 Jan 2019 (exeat weekend) stayed at College.
- 2nd March 2019 Boarding Manager had contact with Brennan's father. Brennan had spent February half term with a host family and not with his father or his guardian (grandmother). His father was asked where Brennan would be staying over the Easter break and who would have responsibility for him. He was asked to confirm if Brennan still had a guardian and that the information the school held was correct. Brennan's father replied on 2nd March 2019 '*His Guardian is his Grandmother as I am often traveling overseas. However, on some of his breaks Brennan preferred to have more independence so his mother organized for him to stay with a host family. However, any important information and the first point of*

contact should always be either with me or his Grandmother. I just talked to his mother, and she agreed that during the Easter break he will be staying with his Grandmother and/or Father at his grandmother's address, especially as he needs to do revision for his upcoming A-levels.'

- 15-17 March 2019 (exeat weekend) stayed at College.
- 03-06 May 2019 (exeat weekend) stayed at College.
- June 2019 - one night boarding suspension for smoking on site - stayed at Sofia's address.
- 14 June 2019 - left boarding on last day of Year 13. Father informed school via email that Brennan would be taking himself and his belongings in a taxi to stay with his grandmother.

NB Brennan's father informed the chair that Brennan's mother changed his air tickets and he flew to Thailand earlier than planned as a result of his boarding ban.

Brennan's father was unable to confirm these arrangements as he was working abroad at the time, other than he paid for Brennan to stay at the school during exeats amongst other fees, and Brennan's mother had arranged host families for him. It is understood from Brennan's father that the accommodation arranged by his mother were B & B arrangements, which she had confirmed were able to accept an under 18 year old. There was no ability to check the suitability of the arrangements as they were arranged from Thailand, nor do school records show they were given the location of the accommodation or 'host family'. However, this is contested by Brennan's father who says he did inform the school when he knew the arrangement made by Brennan's mother. As far as Brennan's father was aware Brennan only stayed once with Sofia, on the first half term break (2017) and then never returned until after leaving Reading University (2020).

3. 19 In January 2019 Sofia was treated at the Norfolk & Norwich Hospital A & E Department for a closed fracture of her left humerus. She had been found on the floor of her home by her daughter having tripped and fallen. It is recorded that Sofia was seen by occupational therapists in the hospital from the Early Intervention Team on 27 January. However, her daughter was with her and has no memory of Sofia being seen in A & E before being discharged with her daughter. Sofia's daughter informed the chair that A & E had promised the community first responder carers would be organised the next day to help get Sofia up; Sofia was described as in shock and she had lost her mobility. However, her daughter reported this support had not been organised as promised, therefore on 29 January Sofia's daughter made a referral to Norwich Community Hub Single Point of Contact[33] regarding an occupational therapy assessment to assist Sofia to mobilise safely following discharge. A Norfolk First Support[34] records note hospital liaison practitioner confirmed a package of care and Sofia was discharged on 30 January for a period of time at her daughter's home. A Norfolk First Support assessment was booked for when Sofia returned to her own home and Sofia's daughter was arranging an alarm and Keysafe. Sofia's daughter took extended leave from work to care for her mother.

3. 20 An assessment took place with Sofia at her home by a reablement practitioner on 15 February 2019, her daughter, and eldest son were present and sharing information with no restrictions was agreed. Norfolk First Support was to prompt and monitor Sofia's medication. A phone referral was made to the Community Health Single Point of Access to request handrails for the staircase, and various aids. Sofia was not eligible for Local Authority funding. She was using the stairs and managing when at her daughter's home but declined to do so in her own home and requested support to stand. She was able to

[33] A co-located team consisting of Community Nursing; Physiotherapy; Occupational Therapy; Continence Services to coordinate integrated responses to patients with unplanned health & social care needs.

[34] Norfolk First Support is a service that provides intensive support in a person's own home for up to six weeks. If for example, they have been in hospital and need support on returning home, Norfolk First Support is there to help a person regain as much independence as possible. Microsoft Word - NFS Leaflet new (norfolk.gov.uk)

stand from her kitchen chair without arms and use the commode independently at the time of the visit. Sofia had been advised by the fracture clinic to put clothes on fully and keep her arm in sling most of the time; she declined to put on her full clothing that day, therefore carers were to encourage her at visits.

3. 21 A referral was made to a pharmacy by a reablement practitioner on 15 February 2019 after Sofia's family found several years' supply of medication boxes untouched. There is no record that this issue was followed up further, but the forgotten medication may have been indicative of Sofia's short-term memory problems. Sofia was to be prompted by family and care workers to take her medication.

3. 22 On the 19 February 2019 Sofia's daughter phoned Norfolk First Support (NFS) and requested an increase in the package of care to encourage her mother with daily living tasks, and a lunch call was added. Her elder brother (Brennan's father) was staying in their mother's home and Sofia's daughter felt he was doing things for her and not encouraging her to do things herself. Feedback from visits reported Sofia was saying she could not do daily tasks and personal care, but she would if prompted and shown how to. Two days later on the 21 February, Sofia's daughter called to inform Norfolk First Support that her mother was going into respite care for a minimum of one week. She had been diagnosed with a urinary tract infection (UTI) and prescribed antibiotics; Sofia's eldest son had to go abroad for a work commitment made before Sofia had her fall, and her daughter had just returned to work. Contact was to be made again when services needed restart.

3. 23 In a phone call on 1 March 2019 Sofia's daughter confirmed with Adult Social Care the care reinstatement. She reported that her brother would be staying with her mother for a period of time, and they may trial 24 hour live-in care while he was away due to a pre-existing work commitment overseas; her mother required a substantial amount of support with her daily living tasks and the family felt that she could not be left alone. Sofia was noted as having a medical history of Osteoporosis, asthma, chronic kidney disease (stage 3) and hypertension. Her recent UTI was now clear and she wanted to return home. Sofia's daughter also reported a symptom which suggested that Sofia may have scoliosis, however this had not been confirmed by a doctor. It was noted by Adult Social Care that Sofia required confidence building when mobilising as she was very nervous. She used a frame or a stick depending on how her mobility was at the time. A 'Keysafe' was in place for carers to access the property, and she would require support with personal care, meals, and medication; she would be self-funding. Attendance Allowance had been applied for, but this took some months to arrive. Although he had to go away for work commitments twice, Sofia's eldest son confirms he was resident with her from her return to her home.

3. 24 On 4 March 2019 in a phone call between reablement practitioner 2 and Sofia's daughter to arrange a restart assessment visit, it was reported that Sofia was meeting a care agency with the aim of hiring a private package of live in care to help Sofia with her recovery. Her eldest son had to travel abroad once more for work and the family felt she could not be left alone. A live in carer would provide support, encouragement, and stimulation to stay active. The visit of the practitioner was put on hold and Sofia's daughter would inform Norfolk First Support of a start date for ongoing care. An assessment visit took place with Sofia on 7 March by a therapy community assistant practitioner. Her daughter and eldest son were present. Various additional equipment was identified along with exercises for Sofia. A pendant alarm was arranged and there are photographs showing Sofia wearing the pendant. Norfolk First Support were informed by Sofia's son that a live-in-carer for a period of two weeks was being trialled from 11 March to 25 March. The service was unable to hold the previous package of care and the family were informed to request the care in future if required.

3. 25 Between 11 March and 24 April 2019 Sofia had the support of 3 live in carers commissioned from a private provider with each one staying for a week on a rota.

3. 26 On the 19 March 2019 GP4 recorded on Sofia's notes "Tripped and hurt back, noted to be a hoarder, family cleared house. Has 24 hour carer input now. DNAR (do not attempt resuscitation) done - patient very clear about it ".

3. 27 A second home visit by the therapy community assistant practitioner took place on 22 March 2019 to check on Sofia's progress with mobility, equipment, and exercises. The practitioner first spoke to Sofia's live in carer who reported Sofia's reluctance to leave her bed for any length of time, to exercise, or to follow advice from her GP to take Paracetamol for pain relief. The carer reported that Sofia was not looking forward to the practitioner's visit as she was worried she would have to do lots of exercise. The practitioner spoke to Sofia on her own in her bedroom to hear her views about what she wanted. The records of the visit are commendable for their detail and are an example of best practice. Parts are quoted to hear Sofia's voice and answers to the practitioner's questions.

> *'Sofia said she wanted to keep her 24 hour carers and be looked after. She loves lying on her bed looking out the window at the magnolia tree she planted 50 years ago, and this is where she is most comfortable, happy, and content. When pain relief was discussed, Sofia was not keen to take it. The therapist explained the consequences of the way Sofia was living at the moment and the problems when people can no longer weight bear. It was also explained that pain in her back is not being helped by the inactivity as the joints will all stiffen when unused. Sofia understood this but said it was a gigantic effort to do anything and it is not as easy as people make out. However, Sofia agreed to take the Paracetamol four times a day to help reduce the pain. She called her carer into her bedroom and asked her to ensure she offers this to her when it is due and she will take it.'*

3. 28 There were no pressure sore problems and Sofia's carer was to check for this and report any change. All ordered equipment had been delivered and the carer confirmed everything was in place to meet Sofia's needs. Sofia's eldest son stated at the previous visit he had ordered a new chair for the lounge to enable Sofia to be more comfortable, but this had not yet arrived. Sofia reported her current chair was very uncomfortable, and she could only tolerate it for about 10 minutes at a time. The therapist discussed follow up in 4 weeks' time to see if Sofia was feeling any less pain and felt more like being active. Sofia was happy with this plan.

3. 29 This period of live in carers coincided with the school record showing that Brennan spent the Easter holidays (1 to 26 April 2019) at Sofia's address. However, there is no mention of his presence. Sofia's daughter confirms she was in constant contact with the carers and they would have reported Brennan's presence to her. Thus, the information given to the school appears to be incorrect.

3. 30 On the 15 April 2019 a Norfolk First Support worker called Sofia's daughter and discussed her current situation. Regarding a fire home safety check, Sofia's daughter explained that new smoke detectors had recently been fitted prior to the live in carers starting; fire safety was a long term concern of the family, and it was agreed the family would check they were in good working order and test them regularly. Sofia had gas central heating, and a CO2 detector was due to be arranged. Sofia did not smoke. Her daughter described her mother as a hoarder which suggested there may have been clutter in the house as previously mentioned in GP notes, but during January and February 2019 Sofia's adult children decluttered the property in preparation for Sofia's return home. A referral to Norfolk Fire and Rescue Service for a home fire risk check is recorded as discussed; Sofia's daughter informed the chair she had no recollection of this advice. She reported her mother's situation was improving; however, she was complaining of back pain due to an old fracture and she had been prescribed morphine patches. Sofia was getting on very well with her private live-in carers and her mobility had improved. Her daughter asked about a 4 wheeled walker and following advice this was purchased privately. Sofia's daughter also reported that her mother was becoming more and more "forgetful", and she was advised

to speak to the GP and to call in future if required. No further action was recorded as required at this time.

3. 31 On 23 April 2019 the therapy community assistant practitioner made a planned home visit. On arrival Sofia answered the door; she was walking without aids and looking very happy. Since the last visit she had been prescribed pain relief patches which had worked really well. She was now up and about and living life more normally. Sofia was managing the stairs, had resumed sleeping upstairs, she was going out in the garden, and also walked to church with her eldest son the previous Sunday morning using her walking stick. Live in care was finishing the next day and there were no plans to continue. Her eldest son was back home and was to remain while she needed him. Sofia's left arm had healed although the range of movement was not as good as before, but Sofia was happy that she was now able to use her arm even although she said she is very right dominant. A 4 wheeled walker for outside was suggested as an option for the summer to enable more walking. Sofia said she really enjoyed being outside. The therapist also discussed equipment and suggested any unused equipment could be returned. Sofia's eldest son said he would like to let things settle a little more before any decisions on this were made. Sofia was happy to be discharged.

3. 32 On 11 May 2019 there was a family meeting at which Sofia and her three sons were present. Her daughter did not attend but she was to be kept informed and a record of the meeting was to be shared with Sofia's close friend who shared Lasting Power of Attorney (LPA) with Sofia's daughter. At this meeting financial matters were agreed; one of Sofia's younger sons managed Sofia's finances as she could no longer manage online banking; her daughter preferred not to take on the additional responsibility for finance. The main points of relevance were - Parameters were put in place regarding Sofia's eldest son's younger children visiting her none of whom were to stay overnight, but to stay in their father's property, and they were to be supervised when visiting. Due to Sofia's improved health the 24/7 care was to change in June to once a day carer visits for personal care with all other duties including meals, health appointments etc being the responsibility of Sofia's eldest son, unless he needed to travel when he would organise increased carer visits and inform the rest of the family when this was required in advance. The care plan was to be reviewed regularly as it was recognised that over time an increase in care hours may be required. Live in carers ceased on 28 May 2019; a reduction in care was agreed. Brennan's father took over all care and household tasks to support Sofia, although he felt uncomfortable undertaking personal care. He reported to the chair that a female friend who had worked in care homes helped Sofia with personal care. Brennan's father later cancelled the carers completely; he reported that Sofia no longer wanted them to come. The rest of the family did not agree with this change.

3. 33 During Brennan's last term at school in the summer of 2019, although there were some good reports regarding academic work, Brennan's school lesson attendance fell from a first year of 95.45% to 70.80%. There was an increase in afternoon absence, and extreme lateness. He was also found to be using a Testosterone Booster which should not be used by under 21's; his parents were informed by email. He was later observed with cigarettes and the school reported this via emailed his parents on 5 June 2019. This resulted in a boarding ban which school records show was spent at Sofia's address. No response was recorded from his parents to the emails. Brennan left school on 14 June 2019; his address was recorded as Sofia's home. Other family members were unaware of this arrangement.

3. 34 GP notes confirm Sofia's daughter had a telephone consultation with GP4 on 18 June 2019 in which she reported her concern about her mother's wellbeing. Her elder brother had moved into her mother's house as carer and there were concerns that her mother was being controlled. The GP advised this was a safeguarding issue and offered to contact Social Services. Sofia's daughter explained she did not want to involve social workers, (Sofia's daughter asked the chair to correct this as she said she informed the GP that they were already getting in touch with Social Services), but felt her mother's self-care is

neglected, and her brother makes videos of their mother reading scripted messages. The GP asked that Sofia be invited to contact them if she wished. The outcome of the call was noted as: “Understands it is safeguarding issue, will try to get mum to see GP”. There is nothing in Sofia’s notes to indicate that she did see her GP in follow up to the concerns raised by her daughter, however, Sofia subsequently saw the practice nurse on 27 June and another GP on 28 June 2019. No safeguarding concerns were raised by the professionals or Sofia at that time.

3. 35 Video messages mentioned above included a video of Sofia made on 7 March 2019 at 23:05hrs and circulated to family members via their WhatsApp group. This video was made available to be viewed by the Panel and shows Sofia stating that she wanted her eldest son to have use of a particular bedroom in the house and carers another. Sofia appears to be looking down as she speaks possibly as if reading notes; she looks at the camera in the last few seconds and with a determined tone in her voice she ends by stressing “This is my house, and I want to be able to make decisions”. The Panel could not reach a consensus that it was ‘beyond reasonable doubt’ that Sofia was reading from notes, and notes written for her, as the picture was in close up and her hands were not visible to show if this was the case.

3. 36 Sofia’s eldest son who was caring for her strongly refutes the safeguarding concern allegations, He also confirmed to the chair that whilst his mother’s handwriting was shaky, she could still write. Her overriding wish was not to go into a care home; Sofia wanted above all to remain in her own home.

3. 37 Also, on 18 June 2019 a letter was received via email by Adult Social Care raising a safeguarding concern by one of Sofia’s younger sons who lives outside Norfolk. The letter raised the following:

- Controlling behaviour towards his mother by his elder brother, for example Sofia making scripted phone calls to her other children including Sofia stating she no longer wanted or needed carers. One of these calls was a video call in which Sofia appeared to be looking down at intervals to read from notes. It was pointed out that Sofia had not been able to write for many years due to shaking in her hands, therefore the messages could not be her own.
- Other family members were discouraged or stopped from visiting their mother, this included Sofia’s granddaughter with whom she was close; Sofia had helped with her care all through her childhood.
- A camera and microphone had been installed by Sofia’s eldest son which she was told was to scare off burglars, but this was the only device in the house. When told what the device was Sofia was angry at having her privacy invaded. The letter also pointed out that Sofia’s eldest son claimed expenses for everything connected with caring for Sofia, but the camera/microphone had been paid for by him.
- The family had concerns that their elder brother was intending to bring his young children from his now ended second marriage in Thailand, to live in their mother’s home against their and her wishes, and this was not in their mother’s best interests or wellbeing. However, they did not want Norfolk County Council to be involved in family dispute about money or Sofia’s house.
- The family were concerned that their mother’s care was being neglected. From 24 hour live in carers when their mother’s health improved markedly, there had been three different companies providing care, two of which had been sacked by their elder brother with no family consultation.
- The letter confirmed that these concerns about their elder brother’s care of Sofia were shared by all siblings, and it was suggested that the concerns be discussed with the other family members. Their contact details were included to aid this.
- The letter ended with a request to investigate the situation due to the writer’s concerns for their mother’s safety and that she was being abused.

The next day (Wednesday 19 June 2019) a Safeguarding consultation took place between the assistant practitioner and the Safeguarding Adult practice consultant in the MASH[35] when it was deemed paramount to establish Sofia's views. It was suggested this could be achieved by a family member speaking with her while her elder son was not present, or by them visiting and facilitating a call to Social Services while they were present. This consultation was followed by a phone call to Sofia's son to request he gain his mother's views about the situation. It is recorded that on the Tuesday 25 and Friday 28 June calls were made to Sofia's younger son but there was no answer, and it is recorded a message was left asking to be called back. However, Sofia's youngest son reported to the chair that no messages were left; he has his phone on silent during business meetings but he always answers messages.

3. 38 Brennan's father, Sofia's eldest son, strongly refutes the allegations made in the safeguarding referral. Regarding carers being cancelled, he asserts that as Sofia's arm healed, her mobility improved and she became more independent, she wanted her privacy back and she no longer wanted them in her home; he maintains Sofia actually told them to leave. He reported to the chair that Sofia consulted her solicitor (around October 2019) who put into writing her express wishes and that she did not want her house to be sold during her lifetime, she wanted her eldest son to look after her, and she did not need any additional carers.

3. 39 Sofia saw practice nurse 4 on 27 June 2019 accompanied by her eldest son who was concerned about foot swelling and difficulty getting her shoes on. It was noted that Sofia was not concerned as the condition was longstanding. The following day, 28 June, Sofia saw GP5. It is unclear if she was seen alone. Notes indicate her son was looking after her, worried her ankles were swollen; likely osteoarthritis. Again, Sofia is noted as not worried about the swelling. There is no record of the concerns raised by Sofia's daughter on 18 June being discussed with Sofia. However, if she was accompanied at the appointment this would have precluded this discussion.

3. 40 On Tuesday 2 July 2019, 9 days after the MASH consultation, in a phone call to Sofia's youngest son who made the safeguarding referral, the assistant practitioner from Adult Social Care explained a discussion had taken place with a professional in the MASH and the decision was to obtain his mother's views. Sofia's son was asked if he would be able to call and speak to her about his concerns, ask what her views were, and particularly if she would like to have any contact or involvement from Social Services. Sofia's son agreed to do this that evening or the next day and then contact the assistant practitioner. The practitioner provided their email address in case this was easier for his reply. Adult Social Care emailed him once more on 17 July asking whether he had further information.

3. 41 Sofia's younger son who made the referral confirmed to the chair that he was specifically requested to ask Sofia whether she would be prepared to make a complaint against her eldest son for the abuse and coercive control she was reported to be experiencing. He reported to the chair that he asked the assistant practitioner to make a visit to Sofia, but after consulting their supervisor, the practitioner explained "until/unless his mother was prepared to make a formal complaint against [his elder brother], then it was against their policy to make such a visit". He explained he was incredulous when he heard this, and if this is the policy it is shameful in his view. He said he told the practitioner this was an impossible ask.

3. 42 A telephone call to Sofia's youngest son was made on Monday 22 July 2019 but there was no answer, and a message was left; he returned the phone call that day. It is recorded he had spoken at length with his mother and she was adamant she did not want to take any action or have the involvement of Adult Social Services; she felt her eldest son was acting in her best interests (that it was reported to Adult Social Services that Sofia felt this is

[35] Multi-Agency Safeguarding Hub: A single point of contact for all professionals to report safeguarding concerns.

contested by her youngest son). It is recorded that Sofia still wished to have contact with all family members; she was not worried about any of the concerns raised in the safeguarding letter, but her younger son commented that he disagreed that his elder brother was acting in her interests, however, he understood his mother had the mental capacity to make this decision. With regards to the concerns of neglect, it is recorded that Sofia's son advised he felt his mother was managing with her personal care (Sofia's youngest son contests this record explaining he told the practitioner the opposite). There were no financial concerns as her finances were managed by her other son, her eldest son had no direct access to finances (Sofia's youngest son contests this record saying what is attributed to him is incorrect as he believed the opposite, but he did not want Social Services to be concerned with financial aspects). Sofia was recorded to be happy with the camera being in place, she had previously been vulnerable to 'phishing' phone calls, and her eldest son had explained he had installed the camera in case these calls came through so he could review what had been said (this record is also contested as being inaccurate by Sofia's youngest son). The matter was discussed with a Safeguarding Adults practice consultant with the decision being there was no role for Social Services or Safeguarding at this time. The other siblings who shared the concerns were not contacted. Nothing further was raised by the family prior to Sofia's death 18 months later.

3. 43 Brennan had spent the summer in Thailand and on his return he travelled straight to Reading University where he commenced studying a degree in Quantity Surveying. In October 2019 Brennan registered at the University Medical Centre, However, he had no contact with GP service during his period of registration, and enquiries found no contact with the Police during his time in Reading.

3. 44 At 17:56 on 27 October 2019 Sofia's daughter phoned NHS 111. She had concerns about her mother's health. Sofia's neighbour and long term friend had gone to visit her and been told by Sofia's eldest son that she was unwell, and he was considering calling the doctor. Sofia's daughter reported that she had spoken to her mother on the phone and her mother had been vomiting. She was very concerned as her mother had previously had a fall and broken her arm, and she had experienced UTI's on a number of occasions for which she needed antibiotics. Sofia's daughter explained that she had Power of Attorney, but her elder brother had recently moved into their mother's home, and he had banned her and Sofia's granddaughter from visiting. She was additionally concerned as her mother had been bed bound for a time after her fall and it had taken months to get her mobile; she asked if a doctor could visit her mother. Sofia's daughter also explained that her brother had a recording device on the phone and a camera, but if he answered the phone she suggested just ask to speak to Sofia. The call handler explained firstly a phone assessment would be required, and it was agreed Sofia would be called, and her daughter would be called back.

3. 45 The NHS 111 call handler phoned Sofia at 18.09hrs that day. A male answered and when asked if Sofia was available the phone was passed to her. Sofia confirmed that she had been sick and felt like vomiting all the time; she thought she had caught a winter vomiting bug. The call handler went through a series of questions about symptoms with Sofia all of which received a 'no' answer. At the conclusion of the questions the call handler informed Sofia that she would ask a member of the Primary Care Service to phone her, to which Sofia agreed. It was explained that this may take a couple of hours.

3. 46 NHS 111 records show that an out-of-hours doctor called at 23:05hrs and spoke to Sofia's eldest son to inquire about her. Sofia's son confirmed that she had not been well for the past 2 days, she had been sick and did not want to eat; she had not eaten that day apart from water and one or two biscuits; he said Sofia thought she had the winter vomiting bug, but he had not heard of this before. His mother thought by not eating she would be better, but everyone was worried about her. He said it was not an emergency, but his brothers and sister were worried because their mother was 88 years old. The doctor asked a series of questions, and her son confirmed her history of UTI's. Sofia's eldest son replied that his

mother walked about a bit, but she had no fever, and she was intelligent and thinking straight. The doctor asked if Sofia would like to be seen, although this may take some hours to achieve. Sofia's son replied that his thoughts were to call the GP in the morning, "But the thing is my brother, but it is my sister who actually called not me". He added "…my sister does not trust me. So, she basically called the what's it 111 number". There was a dialogue between the doctor and Sofia's son about whether he wanted the doctor to visit so late at night to examine Sofia and take a urine sample. Sofia's son explained "the problem is I don't want to cancel what my sister called as she will get mad with me, so if you want to come, you can come". It was noted Sofia's son appeared to want the doctor to recommend that he call the GP surgery in the morning, he said he could not say he cancelled the visit. The doctor declined to do this saying if he wanted his mother examined, she would need to be awake and prepared to be examined. Sofia's son then said he would see if his mother was awake, the doctor replied that it may take up to six hours for someone to come. Sofia was awake and spoke to the doctor herself. She expressed the wish to sleep and see a doctor in the morning. This was the agreed outcome of the call with the doctor saying if Sofia changed her mind the Out of Hours service was open until 8 o'clock. Her son concluded by saying "Ok, as long as it's clear I didn't cancel this, that's all I want to know". He said he would call the GP surgery in the morning.

3. 47 GP records show a home visit was requested by Sofia's son which took place by GP5 on 28 October 2019. A further call and home visit was made by GP2 on 31 October as Sofia was still vomiting. No home visit notes are available for either visit. The GP prescribed antibiotics for a suspected urinary tract infection and Sofia had visits from the community team and nurses. This is the last GP contact with Sofia before her death. Usual routine reviews were disrupted by the Covid pandemic.

3. 48 In April 2020 Brennan left Reading University for Norfolk and his grandmother's home. Government Covid 19 lockdown restrictions and orders to stay at home came into force on 23 March 2020. However, the university had taken the step of observing the Easter end of term closure period, from 9 April to 13 April inclusive. It was during this month that Brennan applied for a place on an artificial intelligence degree starting in the autumn at the University of Manchester having decided to change course.

Incident Resulting in Perpetrator's Assessment under Section 2 Mental Health Act 1983[36]

3. 49 At 19:06hrs on 30 May 2020 Brennan called the Police stating he thought he heard screaming noises coming from next door (he was calling from Sofia's home). He said he first heard it on the 19 April and the Police needed to check it out. At 19:19hrs he made a further call; he had a confused conversation with the operator; *"he thinks it was his dad, he looked so suspicious"*. A repeat call at 19:27hrs which was linked back to the first call from Brennan asking why the Police were not there yet and did they want him to go in. At 20:22hrs a call was received from Sofia's neighbour. The neighbour had opened the door and Brennan had tried to push past her; no injury was caused, and Brennan had left. The neighbour spoke with Brennan's father and was aware there were concerns about Brennan's mental health. His father called the police at 23:19hrs stating his son was at the address and he was worried about him; son suffering with his mental health. At 02:16hrs Police attend but the address was in darkness. A call was deferred to be followed up by officers on early duty. Sofia's neighbour decided not to pursue a complaint regarding the incident.

[36] Section 2 of the Mental Health Act 1983 enables admission to hospital for 28 days if a person is (a) he is suffering from *mental disorder* of a *nature or degree* which warrants the detention of the patient in a hospital for *assessment* (or for assessment followed by medical *treatment*) for at least a limited period; and (b) he *ought to be* so detained in the interests of his own *health or safety* or with a view to the *protection of other persons*.

3. 50 The following day Sunday 31 May 2020 the Police attended Sofia's address for a welfare check on Brennan. Brennan's father thought he was experiencing mental illness and he had previously had issues when in Thailand with his mother. The officer saw Brennan in his bedroom and noted *"He didn't believe I was a police officer despite the fact I was in uniform and showed him my warrant card. He refused to let me into his bedroom and called 999. He let me into his bedroom after a short time on the phone and I had a conversation with him about his concern which centred around the screaming noises he said he was hearing through the wall between his bedroom and the neighbour's house".* The officer tried to explain the noise was coming from central heating pipes, but Brennan refused to accept this. The officer recorded *"it was clear to me after speaking to Brennan he was extremely paranoid and suffering with mental illness so I made contact with the Crisis Team and they called Brennan on his mobile".* The Crisis Team confirmed they would attend at midday, an hour later. Brennan was left at the address with his father and his grandmother. However, the Police received a further call 40 minutes later; Brennan had been talking to his mother on his father's phone, but when his father asked for his phone back Brennan became aggressive, punched his father in the face and then kicked him. Brennan then damaged his father's bedroom door and bedside table. It is also recorded that he had a 'verbal incident' directed predominantly towards his grandmother. Police attended again; however, Brennan's father did not wish to make a complaint; he just wanted his son to receive help. Brennan was reported by his father to be withdrawn and had been playing video games most of the night. The Crisis Team arrived within a minute of the Police and Brennan was taken to the local 136[37] suite to be assessed. On 5 June the decision was taken by the Police that it was not in the public interest to pursue a prosecution of Brennan. An investigation reference was created for a domestic abuse related common assault and minor criminal damage. Brennan's father was listed as the victim. There were no injuries as a result of the assault. It was noted that Sofia was in the lounge and had not witnessed events, and she was also noted as having significant hearing difficulties. Sofia herself was not spoken to.

3. 51 Later that afternoon (31 May 2020) at 15:15hrs Adult Social Care Emergency Duty Team received a call from the Crisis Team, giving an update that the circumstances had escalated, and Brennan had to be moved to a place of safety at Hellesdon Hospital. Police were to stay with him until a Mental Health Act assessment was completed. The details of the incident leading to the assessment were recorded by the Emergency Duty Team and the fact that no one wished to press charges.

3. 52 The Mental Health Act approved mental health professional (AMHP) assessment report commenced at 16:30hrs. It included information provided by Brennan's father that he had been living with his father since returning from university due to closure and lockdown (due to the Covid 19 pandemic), he would otherwise have been at university in Reading. Brennan was described as more aggressive that day. He was found to be quite mentally unwell and at this stage he was detained under a Section 136 of the Mental Health Act, and although compliant during interview there was a time afterwards when he had to be restrained by Police. On assessment there was evidence of thought disorder; he was hearing voices and Brennan himself stated he felt mentally unwell but was unable to expand on this. He said he had been drinking lager, using methadone, and injecting heroin; however, screening later showed no evidence of these substances. He was disorientated in time and place, with poor insight and had lost capacity. He was not responding well; very guarded. Brennan's father appeared to be unaware of any drug use by his son, and he confirmed he had not smelt cannabis. He also related that Brennan had come from

[37] 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.

Thailand to England 3 years ago to study; there was an incident of a breakdown in Thailand, but there was little information on this, also that Brennan had been racially abused as a child due to his mixed heritage and he had spent 2-3 weeks in a centre being weaned off the internet due to addictive gaming behaviour. Since being with his father there had been ups and downs in terms of Brennan's mood and behaviour. Conversation with Brennan was hard.

3. 53 The Approved Mental Health Professional (AMHP) Report identified risk to others from information provided by Brennan's father as evidenced by Brennan's forcing his way into the neighbour's home, a verbal altercation with his grandmother, and punching his father in the face. The AMHP report recorded that Sofia was said to be afraid of Brennan. The report includes that Brennan had a phobia about his grandmother not liking him, and a strained relationship with her. When asked to elaborate further, his father replied, 'a language problem'. A trigger appeared to be when his grandmother had walked into his room that day when he was ordering something on the internet and his reaction appeared dis-proportionate and over the top. (What that reaction was is not recorded). The report noted Brennan did not want to return home and his grandmother was anxious and scared of him.

3. 54 Brennan's father reported he had spoken to Brennan's mother, and she was offering to have him return to Thailand. The report records Brennan's father as hesitant of a formal admission to hospital, due to the possibility of spoiling his chances of a new university course and hoped he would be admitted informally if this was required. Brennan wanted to change course and had applied to another university. His father reported that Brennan had been awarded a place at the 'top' University of Manchester to study AI (Artificial Intelligence) and should commence the course in September; he had no objections to admission.

3. 55 The Approved Mental Health Professional (AMHP) assessment was completed at 21:35hrs with an outcome concluding '*Brennan was calm within the interview, but then escalated by kicking and banging doors. His behaviour is clearly unpredictable and has been a risk to others'*. At one point he had to be restrained by the Police who remained on site. Brennan's two day deterioration in his mental health was assessed as a sudden onset and appeared to be an impulsive reaction to stress, lack of sleep, irritability due to lockdown. His father did not report any issues of addiction or use of illicit drugs (although he did remember use of testosterone after the assessment) – this can cause irritability, rage, anger etc. Brennan was found to have no capacity to consent to an informal admission and needed to be detained to a safe place for further assessment and possible treatment.

3. 56 It is recorded that a copy of the AMHP Report was emailed directly to a named Mental Health Trust staff member on 31 May for final review and to be uploaded on to the Trust's 'Lorenzo' database. The report was uploaded onto the Trust's patient record on 2 June 2020. A final version AMHP report was uploaded to the LiquidLogic Adult Social Care Data System at 15:41hrs on 1 June 2020; as is usual practice this system is not accessible to Mental Health Trust staff.

3. 57 Due to a shortage of beds, Brennan was transferred to Southern Hill Hospital (a private hospital within area) on 1 June 2020. He was detained under Section 2 of the Mental Health Act for assessment and possible treatment. A copy of the AMHP report was shared with Southern Hills Hospital and a copy is on their electronic records.

The Mental Health Assessment:

3. 58 Brennan was hospitalised in Southern Hills Hospital, an out of Trust hospital between 31 May to 18 June 2020. On admission a drug screen proved negative. During assessment Brennan reported experiencing distressing auditory hallucinations telling him what to do and he experienced increased agitation. During his incursion into the neighbour's home

Brennan had believed he was rescuing people whom he believed were being held against their will, it was also to stop the noise from their pipes. He also reported a lack of sleep for days. His father stated that Brennan's grandmother had "hearing difficulties and always watched TV with loud volume and these, with associated noises in the drain pipe has contributed to his inability to sleep for some days". The admitting doctor described Brennan as having a `strained relationship' with Sofia. However, when he was asked about this, Brennan's father indicated that this was due to their differences in their use of language and habits. Brennan's father reported to the chair that he specifically warned the doctor to be very careful as Brennan had managed to 'talk his way out' into getting himself discharged on a previous similar occasion, and the doctor had replied that he could tell if a patient was faking a recovery.

3. 59 It was noted that Brennan had been withdrawn over the preceding 2 years, locking himself in his room playing video games, was paranoid about his appearance, and he seemed to believe his family did not love him or care about him. Brennan reported "fairly recent use of cannabis" (cannabis gummies bought online) before admission but denied use of other illicit substances. He said was getting fed up with his father and wanted to run away.

3. 60 During the course of his admission, Brennan reported hearing the sound of his own voice within his head, he appeared to be withdrawn and demonstrated symptoms of paranoia. His report of "fairly recent use of cannabis" contributed to the impression of an acute psychotic disorder with mental ill health secondary to the use of cannabinoids. Brennan was not very communicative, nor very keen to eat. He was given advice concerning his use of cannabis products and treated with anti-psychotic medication (3mg Resperidone). Risk was assessed as low, apart from the risk of harm to others which was rated as `medium' owing to the altercation with Brennan's father. With supervision to ensure he took his medication Brennan's symptoms improved very quickly.

3. 61 On the day of Brennan's hospital discharge on the 18 June 2020 a discharge planning meeting was held at the Hospital. This was partially managed via video conference. The date had been fixed to ensure that Brennan's father could be at home. A care coordinator from the Mental Health Trust attended the meeting. No risk to others was noted at that time. Brennan was transferred to the care of a community consultant psychiatrist and care coordinator in the Mental Health Trust Early Intervention Team[38], and to his GP for further repeat medication. He was prescribed anti-psychotic medication Risperidone and with Lorazepam available to help with sleep. He had a diagnosis of F23.9 acute and transient psychotic disorder, unspecified F12 -Mental and behavioural disorders due to use of cannabis. The record of the meeting was clear that arrangements were to ensure that Brennan was registered with a GP, had his medication, and would be followed up. Although registered at a Norfolk GP Practice at this time Brennan was never seen by the practice. His medication continued to be prescribed by the Mental Health Trust. Possible future problems identified on discharge were possible disengagement with Mental Health Services, medication non-compliance, and use of illicit substances could impact negatively on his mental health.

3. 62 Brennan's father reported to the chair that his perception of events at this time were different: He reported a doctor informed him of Brennan's recovering and asked his views about discharging him, and based on this information he agreed with the doctor's opinion that extension of the Section order would not be required after the 28-day time limit of the Section 2, he said he was not aware of an actual discharge date. Brennan's father reported to the chair that the doctor said, or had indicated, that he would call back closer to the date

[38] The Early Intervention Team is an all-age team offering enhanced care and treatment to those experiencing their first episode of Psychosis (a delusional or altered perception of reality with hallucinations which can be visual, auditory, and/or sensory). The psychosis may be a transient episode or develop into a serious mental illness such as Schizophrenia. The team offers a time limited intervention, if required people will be referred onto a community mental health team for long term monitoring and treatment. If a transient episode, once recovered a person will be referred back the care of their GP and discharged.

and he had understood this would be closer to the end of 28-day section order. Brennan's father maintains this did not happen and Brennan arrived unexpectedly without prior warning at his grandmother's house a few days later. No discharge date or time, or logistics of how Brennan would travel back to his grandmother's house were discussed or agreed with him. He was happy to hear of Brennan's recovery, but he had expected to have another opportunity to discuss his prognosis, risk factors, or warning signs immediately prior to his discharge when the doctor phoned again.

3. 63 Brennan was followed up by phone due to Covid restrictions on 19 June 2020 by the Early Intervention Team when he reported things were better and he felt he could talk to his family more since admission. Brennan was then seen in person on his own at his grandmother's home on 24 June. He was looking forward to his new university course. Despite denying alcohol and substance misuse on occasions it was noted during this review that prior to admission Brennan had been smoking cannabis 2 or 3 times a week and drinking a bottle of spirits daily (size not referenced). He felt he had experienced a 'mental breakdown' and had had 'odd thoughts'. He denied thoughts to harm himself or others and reported he was no longer using alcohol and substances and had no intention of using in the future. Brennan's father was then spoken to and briefly outlined Brennan's childhood in Thailand and past mental health. Sofia was not spoken to during this visit. An outpatient appointment was booked with a consultant for 1 July.

3. 64 On 29 June 2020 Brennan phoned the Early Intervention Team, and he was invited to the Trust site. It was recorded that he believed the 'state of the house' (clutter), was impacting his mental state, there were lots of boxes around the property. He also felt lockdown was stressful and he felt isolated from his mother in Thailand. He felt he needed help networking with people and finding things to do. He planned to attend university in September and wanted to visit his mother and sister but Covid travel restrictions prevented this. It was suggested he bring his father to the appointment arranged for the following day to discuss the issues.

3. 65 Brennan attended a meeting as planned on 1 July 2020, also present was his father, consultant psychiatrist, and case manager. Regarding medication; no promethazine had been required at night and no Lorazepam had been needed for over a week. The Risperidone prescription was amended to 3mg. Brennan reported that he found the 'clutter' in his grandmother's house difficult to deal with, as was communicating with his grandmother (he did not elaborate and no probing into what this meant is recorded). His father report he had removed some of the items from Brennan's room. During the review no psychotic symptoms were reported or observed.

3. 66 On 2 July 2020 at 19.57hrs Brennan's father called the Police from Sofia's address to report that Brennan had run away from home following an argument with his grandmother about him smoking; the Police record of the call states he was smoking 'weed'. He stated Brennan left the property 30 minutes previously, had just been discharged from a 3 week period in hospital, and could 'jump in front of a bus'; he was not thinking clearly. He added Brennan had run away a few weeks ago before his 'complete breakdown' and had been found at a park. Brennan's father report he had previously hurt a neighbour when suffering a mental health episode, his father thought Brennan was hearing voices, and he believed Brennan had an IQ higher than a doctor but is not socially smart. Brennan was located by phone and he informed the Police he was in a hotel in Norwich, and that his grandmother did not want him there anymore.

3. 67 Officers received information from the mental health nurses who are based within the Police Control Room which confirmed Brennan was open to the Early Intervention Team and had recently been an inpatient under Section 2 following a psychotic episode. There was no history of self-harm or suicide. A welfare check was conducted at the hotel where Brennan was found to be safe and well; he told the Police he had no intention of self-harm. He said there were issues at home; he is made to feel unwelcome and has left to give

himself some space. He had booked a room for that night (confirmed by the hotel) and has funds to stay at the hotel for a month. His father confirmed he was happy for him to remain at the hotel; officers informed Brennan's father that he was safe and well and there were no concerns.

3. 68 The following day on 3 July 2020 Brennan contacted the local Housing Department via telephone reporting that he was homeless. How Brennan knew he could do this is not known. He was dealt with by a housing assessment officer from the Homelessness Team. Brennan reported that he had recently returned from university in Reading to live with family; there had been an argument about his smoking in the garden and he had been asked to leave by his grandmother. He had booked himself into a hotel in the town funded by his mother who was in Thailand.

3. 69 The housing officer spoke to Brennan's father, who confirmed he was the carer for his 88 year old mother (Sofia). He advised that she did not remember what she had said and was not aware of the consequences of her decisions. Brennan's father confirmed that Brennan had mental health issues for which he was supported by the Early Intervention Team and he had a dedicated support worker. He advised he had reported Brennan as missing to the police the previous night and had also contacted the Mental Health Crisis Team. He had spoken to his mother and reported that Brennan could return home. Brennan was advised of this. His father was told should Brennan refuse to come home he could contact the Housing Department for further assistance regarding homelessness, and for concerns about his son's mental health he should contact the Mental Health Crisis Team or Adult Social Services. The case was closed as 'advice and assistance' as the client was not homeless.

3. 70 Brennan attended an arranged appointment on 15 July 2020 at the Early Intervention Team. The initial part of the conversation was focussed on his father. Brennan admitted to not overly knowing his father; he said he always looked busy and was 'no fun'. He had been in contact with his mother about leaving the house and she had agreed to finance a B & B until university started in September. Brennan denied any argument with his father before moving out, and he got on well with the B & B owner; they watch television together and played chess. He said he was feeling well at this time and was not experiencing any symptoms of mental ill-health. A further appoint for two weeks was planned along with medication review.

3. 71 The planned review took place on 29 July 2020. Brennan appeared preoccupied with his mobile phone. He reported feeling well in himself but had limited contact with his father since moving out. He denied any current symptoms or aggression. When suggested that he was quiet he replied he was always like this. Thoughts of harm to himself or others were denied at this time. Consent was sought to contact student support when he went to the new university in September to ensure he received ongoing support; the possibility of disabled student allowance was also discussed. Brennan said he had contacted his mother relating to his earlier admission in Thailand, but she did not have any records and the unit had not kept any either. The plan; Medication was reduced to Risperidone 2mg and a further appointment made for 26 August. This appointment was missed. Brennan was phoned and informed that an application for disabled student allowance had been sent to the home address along with supporting documents. He confirmed he was aware of his medication and he was taking it. A further medical/joint meeting was planned for 16 September 2020. A physical health appointment on 2 September was cancelled by Brennan.

3. 72 On 16 September 2020 Brennan did not attend a planned review with his consultant psychiatrist. After being texted a reminder, he contacted his care coordinator 30 minutes before the appointment to say he was catching a train to Manchester to start his degree. Brennan said he was still compliant with medication and had collected a new script from his GP prior to leaving. The consultant raised concerns about poor medication compliance

with his antipsychotic medication as his last prescription was collected from Mental Health Services on 29 July 2020. Despite encouragement to enable the Trust to make onward referrals for further support, Brennan informed the care coordinator he did not want the Mental Health Trust to contact the student support team at the University of Manchester, he would do this himself, and did not want an onward referral to the Early Intervention Services in Manchester. Brennan agreed to the care coordinator calling him in one week to discuss options of further support in Manchester. The psychiatrist requested Brennan's GP Practice inform him if Brennan had collected his anti-psychotic medication. No correspondence was received from the Norfolk GP Practice as Brennan's care had ended at the surgery by the time the letter was received, and no medication was ever issued from the Norfolk GP surgery.

3. 73 Brennan's father called the team on 18 September as he was struggling to pay the new University fees, not financially but due to the system, this was confirmed as resolved after the call when the team contacted Brennan. He moved into one of the university's halls of residence on this day[39] and started his degree course in the Department of Computer Science with a 2 week welcome and induction programme on 22 September 2020. Teaching began on 5 October. Due to the Covid pandemic and a large rise In cases within the student population and the city as a whole all teaching moved online. Brennan's overall attendance was only 11%. He attended the first two meetings with his tutor in weeks 2 (w/c 12 October) and 3 (w/c 19 October) but he missed subsequent weeks. He attended the first workshop for his course commencing 12 October but was recorded as absent from subsequent workshops for this unit plus others.

3. 74 The Early Intervention Team care coordinator phoned Brennan on 1 October 2020. He was needing to self-isolate as per university rules due to Covid. When asked he confirmed he had run out his prescription, but said he was no longer keen to remain on medication. Brennan confirmed he had registered with a GP and would forward the details via text, but he again declined the offer for the team to pass information on to student support or local mental health services. The care coordinator discussed the stress a new environment can bring but Brennan reiterated that he felt 'well'.

3. 75 On 6 October 2020 Brennan was confirmed as registered with a Manchester GP, however he had no GP appointments during his time at the University. On 14 October a letter was sent from the Norfolk Early Intervention in Psychosis Team to the Manchester GP practice (received 21 October 2020) advising that Brennan had last taken Risperidone on 1 September 2020 and had declined referral to the Early Intervention Service in Manchester. His mental health was reported to be "stable with no psychotic symptoms since his discharge from hospital". The care coordinator stated Brennan had informed them on that date he had run out of medication and did not wish to continue. However, the letter to the Manchester Practice included "there is risk of deterioration due to stopping medication" and they were asked to refer to a local Early Intervention Team "if any concerns regarding his mental health." Consideration was given to discharging Brennan from the care of the Norfolk Early Intervention Team; however, he remained open to the team in case he returned to the area.

3. 76 On 16 November 2020 the student support system within halls of residence[40] was triggered when one of Brennan's flatmates emailed residential life advisor 2 asking for advice and support as they were worried and a bit scared by Brennan. They reported he kept himself to himself and did not socialise much; he spent almost the whole time in his room, only leaving to eat. Recently the other flatmates had been annoyed/suspicious with Brennan because they caught him stealing other people's food from kitchen cupboards. They said

[39] The hall of residence is configured into ensuite self-catering accommodation in flats of 10 students.

[40] Support in halls of residence is provided in the first instance by residential life advisors who are post graduate students or staff with a role elsewhere in the University, and the residential life coordinator is a full time member of staff. Training has been undertaken for these roles (discussed in Analysis section of this report).

Brennan would bang on the wall separating their rooms which disturbed them late at night. Brennan then began to feel the other flatmates were excluding him deliberately and talking about him behind his back. The atmosphere in the flat had deteriorated since then. The flatmates said they knew that Brennan had a history of mental health problems and had been Sectioned at least once before. They also said that Brennan often drank and would get drunk at least once a week but often more regularly. He was more open with the other flatmates when drunk. However, it was reported the last time he was drunk in the kitchen he shouted a lot at the other flatmates and 'let rip' about his grievances to them. The residential life advisors provided information about who to contact for support or in the event or further issues promised to escalate the concerns. A report of the visit was shared with the relevant residential life coordinator who was senior to residential life advisors 1 and 2.

3. 77 The following day, 17 November, the residential coordinator tried to contact Brennan by phone, and then visited his flat with residential life advisor 4 asking to speak to him. The record from this visit notes that Brennan was agitated and paced up and down the corridor. Conversation was difficult as he would not engage; he was adamant that everything was okay. The only things raised by Brennan of note were that he had family issues and that he didn't have a good relationship with his father. What the family issues were was not elaborated. He had financial issues and was thinking that he may have to drop out of university and get a flight home after lockdown. He was encouraged to consider an appointment with the university's Counselling and Mental Health Service, but he reacted negatively to the suggestion. He was reminded of sources of support, including the Residential Life Team.

3. 78 A further visit took place next day, 18 November, by the residential life coordinator with another residential life advisor 5. Again, Brennan was difficult to converse with and he immediately wanted them to leave. The concerns of the flatmates were raised with him, and it was stressed that the focus was on trying to help him, not to punish him. Brennan was very dismissive and did not acknowledge any issues, citing he was either too drunk to know what happened or there was no problem in the first place. The residential life coordinator discussed Brennan with their manager, senior residential life coordinator 6 that day and made a file note concluding having both spoken to Brennan and provided advice and support to the flatmates, the next steps agreed were to give him the opportunity to show he would not repeat any of the behaviours causing the complaint and to remain in contact with him.

3. 79 Between 11 and 19 November 2020 the Norfolk Early Intervention Team dealt with communications with Brennan's father and texts from Brennan himself. His father was concerned that Brennan was no longer interested in his current course and may be considering moving back to Thailand which he suggested neither parent wanted. Over the coming days his father was advised that expressing his concerns to the university's student support could be a beneficial option. Brennan had also been contacting the team to enquire about accommodation other than with his father when he returned and not in university accommodation. He too was directed to student support if wanting to stay locally in Manchester, or to call the team if wanting to return to Norfolk.

3. 80 After speaking with the Early Intervention Team Brennan's father called Manchester University switchboard on 19 November 2020 expressing concerns about Brennan. The switchboard operator emailed the duty officer in the Counselling and Mental Health Service to say: *"Can someone please contact concerned parent [name and number] regarding his son [name and student ID] who is studying Artificial Intelligence".*

3. 81 As there was nothing in this email to suggest the concerns were mental health related and because Brennan was unknown to the Counselling and Mental Health Service, the duty officer forwarded the email to a colleague in the university Advice and Response Team. The university describes this as a proactive team whose function is to follow up instances

where students need support that is either complex or which crosses a number of different parts of the university, including where that involves support from specialist services such as the Counselling and Mental Health Team. Advice & Response Team staff member 1 reviewed the information and highlighted the case to their manager, staff member 2 on the same day who contacted the Residential Life Team that afternoon by email, asked whether Brennan had come to their attention, and suggested they conduct a discreet welfare check. The residential life coordinator responded and explained the interactions their team had had with Brennan over the preceding days (and included the relevant contemporaneous notes). The residential life coordinator and advice & response 2 also discussed the matter by telephone that evening.

3. 82 On 20 November advice & response 1 called Brennan's father and noted his concerns about Brennan's erratic thinking, impulsivity, and that he had recently looked tired and thin. It was noted during the call that Brennan was hospitalised the previous summer for 2 weeks for mental health support and that he should be on medication, but his father did not know what this was, although he believed he had stopped taking it. Brennan's father described his recent behaviour as unusual, but also stated that he did not believe he was at risk to himself or others. He requested that the university contact Brennan's GP. Following the call with Brennan's father, advice & response 1 contacted the University's Counselling and Mental Health Service for advice and to seek their support in contacting Brennan (see further information below). There was no agreement made to continue to liaise directly with Brennan's father. The notes of this call record:

- *Parents are worried about [Brennan's] erratic thinking, impulsivity.*
- *Mum thinks he looks tired and thin (not eating properly, won't cook).*
- *[Brennan] was hospitalised last summer 2 weeks (Mental health: imagining things, physically assaulted a neighbour).*
- *[Brennan] should be on medication, but dad thinks he's stopped taking them.*
- *Dad doesn't know what the medication was maybe antidepressants and something to help [Brennan] sleep.*
- *Student was seeing a counsellor at home but now doesn't have any MH support. Dad has called [Brennan's] old counsellor who suggested calling [the university's] counselling service.*
- *[Brennan] was advised to register with DASS* [The University's disability support service], *but Dad doesn't think he has.*
- *[Brennan] keeps calling Dad asking for money to change course and has been applying for lots of high paid jobs he's not qualified for.*
- *Dad confirmed that this is unusual behaviour for [Brennan] and he thinks he has stopped attending classes.*
- *No risk to himself or others, but Dad is worried about [Brennan's] reaction to disappointment. There's an opportunity for [Brennan] to study in Thailand (Mum from Thailand and sister studies there).*
- *Dad thinks [Brennan] will take off without letting anyone know he's not thinking straight.*
- *[Brennan's] father would like the University to contact the students GP.*
- *Note; at the moment [Brennan] is unaware that his father has been in touch.*

3. 83 Following this call, the duty officer (a qualified mental health nurse; counselling 2) in the Counselling and Mental Health Service called Brennan on Friday 20 November. He recorded in his notes that he managed to speak to Brennan after a couple of attempts. Brennan was not keen to engage in a discussion and was clear that he did not want any support.

3. 84 On Monday 23 November, the Head of the Counselling and Mental Health Service (counselling 3) and the head of the Advice and Response Team had a call to review the situation and assess whether any further action or escalation was required. They balanced all the known background (including the fact that this was the first time Brennan had come

to the attention of any of the university's support teams). They concluded that as Brennan was not keen to engage with the Counselling and Mental Health Service, trying to force him to do so at this point could be counterproductive. They considered asking a member of the Counselling and Mental Health Team to visit his flat, but it was unclear if this would be helpful. It was agreed to escalate Brennan's case to the statutory services if things did subsequently escalate. In addition, Brennan was provided with details of the Greater Manchester Mental Health crisis line, information about the support they provide, and the situations in which contact was recommended. In summary, the team concluded:

> *On balance, despite the reports of occasional odd behaviour from his flatmates and the call from this father, when this was taken together with Brennan's unwillingness to engage with the support offered to him and the fact that there did not appear to be any obvious signs that he was at immediate risk to himself or others, the best course of action was to continue to monitor the situation and review it again if anything escalated. In the meantime, Brennan had been provided with details of the various University support services and information around the steps he should take if his condition or situation deteriorated.*

3. 85 In a further call to the Early Intervention Team in Norfolk on 26 November, computer records show Brennan's father expressed his worries that Brennan had a bank account which contained thousands of pounds and he was concerned that he would access this to purchase drugs or alcohol. Brennan's father confirmed that during contact with his ex-partner (Brennan's mother) in Thailand, she reported no concerns related to the situation. It was confirmed that the service user was not reporting psychotic thoughts or thoughts of self-harm. His father was advised that if he feels any threat from the service user to contact emergency services.

3. 86 Brennan was written to by the Computer Science Department on 26 November 2020 about his absence from a number of scheduled tutorials and workshops and the fact that he was behind with his coursework submissions. He was invited to attend a meeting with his first-year tutor on 30 November to discuss these concerns. When Brennan failed to get in touch with his tutor, he was sent a formal warning about his attendance on 2 December and was asked to contact his tutor by 7 December or risk exclusion from his course.

3. 87 On 3 December 2020, Brennan contacted his tutor via email to say: "*I have been dealing with family issues regarding finances, I am planning to stay on the course. Is there any work i am required to catch up? currently I've been going through the materials throughout the past few weeks and planning on catching up with the coursework soon."*

Brennan's tutor replied on the 8 December suggesting they meet the following day to discuss his progress and create a plan to help him catch up with the course. Brennan did not meet with his tutor on that date (he had already left Manchester), and he made no further contact with his tutor.

3. 88 There is a swipe entry system for the front door of the accommodation in which Brennan lived. His card appears to have been used very little during the period he was in residence (which is corroborated by his flatmates who said he barely went out). The last time his card was used to enter was the afternoon of 1 November (albeit it was tried twice on the afternoon of 3 November and appears not to have worked). It is not required to swipe to leave the building, therefore the university has no record of when Brennan last exited.

3. 89 On 4 December 2020 the Early Intervention Team in Norfolk received telephone contact from Brennan's father reporting that Brennan had returned to the local area the previous week but had not visited his father. He believed this was because Brennan was attempting to access his savings account, he also remained concerned about Brennan's unrealistic study plans which changed frequently. At this time his mother in Thailand was reported to

have no concerns about Brennan. He was asked to contact the team if the service user returned to the local area again.

3. 90 Brennan's father called the Early Intervention Team once more a few days later reporting Brennan's return from university again. The clinician recorded he was not able to identify, 'any odd or concerning behaviours', apart from he was concern about the possibility that Brennan had spent money excessively possibly gambling as he had done this before, and what was described as 'unrealistic study options'. It was explained that Brennan would need to agree to be seen by the Team, hence his father agreed to discuss a possible appointment with his son which was offered for the following week with the Team also texting Brennan to confirm. Brennan's father contests this record reporting to the chair that he wanted someone to check Brennan's mental health as he had been very worried about him and in his view the university had apparently ignored his request to give Brennan a mental health assessment. Brennan's father said he wanted the Early Intervention Team to come as soon as possible, hopefully the same day, as he had expected Brennan to leave soon, possibly the same day, to go back to Manchester. Brennan's father did not know that Brennan had already decided to leave the university.

Events Leading Up to the Fatal Incident:

The Review chair and Panel members are aware that the family had many questions concerning the following events, therefore more detail than usually found in the chronology is given in the following paragraphs.

3. 91 It is not known exactly when Brennan returned to Norfolk, where he was staying, or why he suddenly left Manchester. In a subsequent witness statement, his father stated he had been surprised when Brennan turned up briefly at his grandmother's house in early December at around 17:00hrs but he did not stay long; he had run out of money and his father transferred funds to enable him to buy a train ticket. He thought Brennan had then returned to Manchester. However, he returned once more some days later at approximately 21:30hrs and asked to stay. Around midnight Brennan's father called the Police stating he was worried about violence as his son who had previously been Sectioned was acting strangely; he was staring at him. He was worried for his and his mother's safety but could not clearly articulate when the call handler asked why this might be. When asked about his mother Brennan's father said she would not hear; she's deaf. Brennan had entered his father's bedroom and asked to use his father's phone to call his mother, his father had refused because he had paid for Brennan to have a new iPhone and he was concerned Brennan would delete important e-mails and messages on his phone as he had in the past. Brennan was told to take a charger to his room to charge his own phone. Brennan had slammed and kicked a door in frustration, although it was reported no damage had occurred.

3. 92 While the call was taking place, the first officers were dispatched to the address at 00:2:35hrs and advised that the call was Grade 'A' (immediate response). The officers were informed enroute that it was difficult to get information from the informant (he sounded anxious on the tape), but the suspect was given as Brennan, and '*that their 19 year old son is being violent towards them'*. Officers were informed by the dispatcher '*that police haven't been there since July' and the call 'is still incoming'.* Three officers in total attended; officer F was involved for the first time and officer B and sergeant A had been involved during the incident on 31 May 2020 and were therefore aware of Brennan's history. The sergeant arrived separately.

3. 93 Brennan's father reported to the chair that at the time he made this call Brennan was standing about 1 foot away from him during the entire 999-call, and he was expecting Brennan to grab or kick the phone out of his hands and start attacking him at any time.

3. 94 Officers F and B arrived at Sofia's home at 00:07:47hrs and switched on their body worn cameras[41] on reaching the front door; they were let in by Brennan's father who appeared distressed, he indicated that Brennan was upstairs and the officers went to his bedroom. On entering Brennan's bedroom which was in darkness; an officer switched on the light revealing him in bed. In body camera footage Brennan can be seen lying under a duvet wearing a 'hoodie': he appeared subdued, almost half asleep, and he was practically monosyllabic. When he did speak, he spoke very quietly and was difficult to hear. Obtaining answers to questions was difficult. After initial pleasantries the officers agreed officer F would go and speak to Brennan's father. The third officer, sergeant A, arrived in the bedroom. Officer B then had communication with Brennan as follows:
Officer B – *"What's happening, why has dad rung us?"*
Brennan states that he has asked him for a phone and that is it.
Officer B – "*So you haven't attacked him?"*
Brennan – *"Nothing"*
Officer B – *"Damaged anything"*
Brennan – *"Nothing"* – states that he just asked for a phone.
Officer B asks him whether it is in his room; that it wasn't last time. He doesn't say anything. The officer then asked him how he has been, and he stated '*fine'*.
Officer B – *"So why would dad say that you're being violent?"* He didn't respond.
Officer B asked him whether he had damaged anything or thrown anything around and during this conversation he just shook his head. The officer asked him whether he had touched his dad at all or pushed him away. He shook his head and said something that was inaudible.
Officer B asked him whether he had not got his own phone. He said *"no",* and officer B clarified that he didn't have his own phone and again he says *"no".*
Officer B – *"Why do you need a phone this time of night?"*
Brennan – *"To call my mom".*
Officer B then asked him whether his Nan was there, and he said '*yeah'.*
Officer B then said to him *"bear with me a second".* The officer opened the bedroom door (00:11:43) and went along the corridor to the landing at the top of the stairs. From there the officer would likely be able to hear the conversation going on downstairs (it is picked up faintly on their body worn camera).

3. 95 Whilst officer B had been with Brennan, officer F met Brennan's father on the landing and as they went downstairs, Brennan's father indicated a closed bedroom door where his mother was and said she could not hear anything. Once downstairs Brennan's father gave details of Brennan's background including about his serious mental health problems. He observed that one of the officers in attendance arrested Brennan last time Brennan had been violent towards him, assaulted the next-door neighbour, had been violent to his mother in Thailand, and had been Sectioned previously for 3 weeks. He explained that Brennan was very intelligent and knows what to say to a doctor to get himself released.

3. 96 Officer F asked what had happened that day and Brennan's father explained Brennan was at Manchester University but he had not been studying and decided to quit. He had arrived unannounced at 21:30 hours; he had given him food and tried to be good to him. Brennan had come into his room demanding his phone, but his father refused as his phone had private and confidential information on it and last time Brennan had thrown it in the toilet. He had bought Brennan an iPhone of his own. At this point (00:11:28 hours) sergeant A arrived and liaises with officer B who reports *"he's fine* [meaning Brennan] – *he's not* [referring to his father] indicating that he appeared anxious.

3. 97 Brennan's father continued to tell officer F that Brennan was threatening him, he wanted to charge his phone; he asked where his father's charger was and said it was his charger.

[41] Norfolk & Suffolk Constabulary Force Policy includes the expectation that body worn cameras are used for certain incident. This includes when attending domestic abuse or suspected domestic abuse incidents, and when attending any incident in order to make an arrest.

Brennan's father stated, *"he was staring at me; last time he did that he started getting violent with me."* Officer F asked what he meant by getting violent with him and was told that he had kicked the door down; that the door is still damaged from last time. Sergeant A stated to him that they had come last time. Officer F asked whether Brennan had hit him, and he replied *"not this time, but he was threatening me, the way he was staring at me…"* He stated that Brennan was repeating himself about the charger and the phone like a broken record. Officer F asked whether he believed that Brennan was about to assault him and his father replied *"well I was really frightened…* [although he did not really finish the word]*; that was exactly what he did before he hit me last time. He was acting completely irrationally."* Sergeant A stated that was last time and their colleague had stated that Brennan seemed fine. His father replied that he [Brennan] was either playing games or trying to threaten and worry him, but there were knives in the house – *"he could kill; he could do anything to us; he is not stable. I can hardly sleep at night now."* Officer F asked whether there is anywhere else that Brennan could stay and was told *"no"*. Sergeant A said they would go and have a word [with Brennan] and his father told the sergeant that '*he is hyper intelligent'*, The sergeant said they had met him. Brennan's father added *"he is threatening me verbally and staring at me, like staring at me like hit me and repeating himself, my phone, my charger…"*

3. 98 At 00:13:52 sergeant A and officer B headed towards Brennan's room. Brennan was still lying under the duvet with hoodie over his head. The following conversation took place with Brennan:
Sergeant A – *"Hello mate, are you alright?"*
Brennan– *"Yeah"*
Sergeant A - *"We have met before…, you look better, it was quite a while, it was in the summer, do you remember…no, you probably wouldn't. You are feeling fine now?"*
Brennan – *"Yeah"*
Sergeant A – *"Have you been staring at your dad?"*
Brennan – *"I just asked him for a phone and then* (inaudible)"
Sergeant A – *"What did you ask for, your phone?"*
Brennan – *"I asked for the phone"*
Sergeant A – "*What phone?"*
Brennan – *"His phone"*
Sergeant A – *"his phone, what for?"*
Brennan – *"To call my mom"*
Sergeant A – *"okay, have you got a phone?"*
Brennan – (no response appears to be made)
Officer B – *"It is quite simple, have you got your own phone to call your mom or do you always use your dads, because he is saying that he bought you an iPhone?"*
Brennan did not respond.
Sergeant A – *"We are not trying to be funny, I was just wondering if you always use his phone, because he says you have got your own, so can you use your own phone to ring you mom?"*
Brennan mumbled something and sergeant A said *"sorry"* and leaned forward to hear and he mumbled something again and the sergeant says *"no…, okay that's fine, I don't want to upset you, I just thought that you could use your own phone…so are you just planning on going to bed…sleep?"*
Officer B said *"or have you got anywhere else that you can go. Have you got mates that you can go to for tonight because obviously dads a little bit upset isn't he for some reason. Dad's saying that you were staring at him like you were going to get a bit violent or a bit aggressive with him."*
Brennan said something that was inaudible on body worn camera recording, but Officer B immediately responded saying "*I am not saying that you have to but if you are more comfortable going somewhere else and we can take you somewhere or are you happy to stay here; are you going to be alright if we leave you here or do you think things…"*
Brennan said something which was again inaudible on the recording.
Sergeant A – *"We just don't want to leave and then you two have an argument again…"*

Officer B interjected *"and we get called back."*
Brennan appears to stay silent.
Sergeant A – *"So you are going to go to sleep now are you?"* Again, there was no immediate response and sergeant A then said to him "*have you rung your mom?"* He responds *"no*". He was then asked whether he wanted to ring his mom. Brennan said something about a phone.
Sergeant A – *"So you want to use his phone, where is your phone?"*
Brennan – *"No idea"*
Sergeant A asked whether he had looked for it, and Officer B asked him whether he had bought another phone after he threw his other one away, because that is what he did in the summer, thrown his phone somewhere and couldn't then find it.
Brennan – "No"
Sergeant A – *"So you don't have your own phone"*
Brennan – *"No"*
Sergeant A suggested that if his father was not going to let him use his phone then maybe he would let him in the morning when he had had some sleep. Officer B told him that it was quite late.
Sergeant A – *"What is going to happen when we leave?"*
Brennan – *"Sleep"*
Sergeant A – *"Go to sleep – yeah, and you are not going to speak to your dad, interact with him, you are going to let him doing whatever he is doing and you're going go to sleep, yeah…promise".*
No response was heard but sergeant A can be seen nodding in his direction. At this time Brennan was not in view of the body worn camera.
Sergeant A – *"Alright, alright, we will leave you to it, alright, nice to see you again – do you want me to shut the door – see you later".*
Officers left the bedroom at 00:17:25hrs. Throughout the above conversation the position of officer B's body worn camera is such that Brennan is not always in the camera's view.

3. 99 It appeared that at the behest of the officers Brennan had agreed to stay in his room, sleep, and not to speak to his father. Meanwhile officer F remained with Brennan's father downstairs discussing the situation. Officer F explained that as Brennan was 19 years old and legally an adult, he did not have to have him living there; he could tell him to leave and he would have to go to the council. Brennan's father stated, *"it's such, I know it's difficult, I can't live, I can't sleep at night."* They continued to discuss Brennan and him not being welcome there, and his father again explained about university and that *"I can't handle him in the house, I am sorry."* Officer F explained that the Police did not have powers to Section him; it was not a public place [meaning the house]. Brennan's father repeated "*I am worried for my life; I am worried for my life."*

3. 100 Officer F asked Brennan's father what he was seeking from the Police and what he would like them to do for him. He stated firstly he was glad they came because he [Brennan] had now gone from his room, but the moment the Police were gone, he felt he would be back in his room and threaten him again. Officer F asked – *"Okay, what would you like us to do about it?",* Brennan's father replied *"Take him away please; I don't know what to do with him; I have tried everything I can. I have bought him an iPad, bought him a new laptop, paid his university…".* Officer F explained he knew Brennan had been intimidating and it had been scary that night, but no criminal offences had been identified for which he could be arrested so they could not [take him away], unless their colleagues find out something, they could not arrest him and take him into custody.

3. 101 Officer F and Brennan's father then discussed whether there were any friends etc. where Brennan could go, but there was no-one; he had been trying to get him to go back to Thailand. Officer F explained if Brennan was asked to leave that night he would not be able to find any accommodation, but if he left tomorrow he could go to the council as effectively homeless. He stated the only difficulty was what they did with him that night and he would have to discuss with his sergeant. Brennan's father responded, *"you can listen to my heart,*

I am scared…he is so irrational. When in Thailand he shot his mother with a gun." He explained it was a BB gun from point blank range and she had to go to hospital; he had shown extreme violence in the past.

3. 102 Sergeant A joined officer F and Brennan's father and stated *"he is really calm, he is going to sleep now, he is not going to speak to you or interact with you, he just wanted to use your phone and ring his mom."* Brennan's father asked what was wrong with his phone and last time he damaged his phone. Sergeant A explained that Brennan is aware he is not getting his father's phone and he was going to go to sleep. His father stated that he was *"…worried, really worried."* He then mentioned Brennan's mental health once more and the discussion ascertained an appointment had been made for someone to see Brennan the following Wednesday. Sergeant A said *"he is going to go to sleep, he is calm, he is just going to go to sleep. He said that he is not going to speak to you so if you want to ring the Crisis Team then you can, but at the moment he is not actually doing anything for us to…."* Sergeant A advised Brennan's father to go to his own room and shut the door, but he said he had no lock on the door and that is the problem.

3. 103 Officer B stated *"we haven't got anywhere to take him. He has got nowhere to go. We are not going to take him to custody because he has stared at you in an aggressive manner. Custody is not the right place for him. Obviously, we met in the summer. He is mentally quite unwell isn't he, or he can be. Custody is not the right place for him."* Brennan's father asked whether he would have to call the Crisis Team again and Sergeant A stated, *"if you feel that you need to."* They discussed the council further and Brennan's father mentioned Brennan had not been taking his medication. He was guided to contact the Crisis Team or whoever gave him his medication. Brennan's father responded, *"I hope I am alive tomorrow, that is all I say."* Sergeant A told him to shut his door and put something against it and repeated that Brennan is going to sleep. Officer F explained it was about 7 hours to the morning and it can be explained in the morning that he wants Brennan to leave. At the end of the discussion Sergeant A asked Brennan's father whether he wanted them to wait until he had gone to bed before leaving; he made his way upstairs and said, *"thank you".* The officers then left the address.

3. 104 After the fatal fire it emerged that sometime after officers left, Brennan's father left the house and went to his own home nearby. He reported to the chair that he remained fearful of his son and left with the intention of returning at 8.00am to evict Brennan from the house and to send him for a mental health assessment.

3. 105 Officer F recorded the investigation at 01.05hrs as a non-crime domestic abuse investigation which highlighted that no criminal offences had been identified. Brennan's father had confirmed that no violence had been used and he had not been assaulted, therefore no crime was identified to be recorded. The parties were separated and as the house was large it was considered the parties could easily avoid each other for the night. It was agreed that parties would sleep in their rooms and in the morning Brennan's father was going to tell him to leave and try to obtain accommodation from the Council. Sofia was not seen or checked on during the visit. The body camera footage showed her bedroom door to be closed. (Sofia's daughter commented that this was not usual; all her life she had always known her mother to have her bedroom door ajar). At 03:47hrs tasks were sent to the MASH Adult Safeguarding and Norfolk Constabulary Mental Health Team. Sadly, due to the timing of events these tasks were not reviewed by the MASH until after the fatal fire.

3. 106 At 06:41hrs a phone call was received by the Fire & Rescue Service from a person who was delivering a newspaper to Sofia's home reporting the smell of smoke which appeared to be emanating from the bricks of the house. Two appliances were dispatched. The Police received a call from the Fire Service at 06:59hrs; persons were believed to be in the address. Paramedics were on the scene by 07:16hrs. Tragically Sofia's body was found on the floor of her bedroom. She had sustained burns to her hands, arms, and face. At

the sentencing hearing one of her younger sons suggested she may have opened her bedroom door to see what was happening, and this had resulted in her burns. The cause of her death was given as smoke inhalation.

3. 107 Investigations identified the fire started in a cupboard under the stairs; a chair had been placed in front of the cupboard door. The extent of flame and heat damage was limited to 2 floors, but a family member reports smoke damage affected the whole house. The source of ignition was a naked flame - lighted paper or card. Damage was noted as a 6 to 10 square metre horizontal area of damage by flame and/or heat, and a 51-100 square metre horizontal area damaged by flame and/or heat and/or smoke and/or water. Checks were made to establish if any previous incidents had taken place at the property; none were found.

3. 108 At 08:07hrs a 999 call was received by the Police from Brennan's father. Relevant information from the call is given below:

Brennan's father started by saying – *"hello, yes, I called 999 last night about my son and the police came, but I was so scared I left my house, I have now got the fire alarms going off at my house at (address given is Sofia's home)."*

He went on to provide his name; he stated his mother was there and that his son is *"absolutely mental, I asked the police to come last night…"* He stated that he was on his way back to the house, that he stayed at a friend's house last night because he was so scared that he couldn't live in the same house. He said the fire alarms on his phone were going off.
Brennan's father stated that he was scared that his son had done something to the house. In answer to a question about where his son was, he stated that his son was in the house last night. He said, "*the police talked to him and they said that they weren't going to do anything last night."* He repeated that his fire alarm is going off on his phone – it was established that he had an app; he had just woken up and seen the alarms on his phone.
Brennan's father provided details of the address he was at and the call was concluded that someone will come and see him at his address.
CAD NC-11122020-67 also details an update from the fire service that they had also received a telephone call from Brennan's father.

3. 109 After a lengthy search by the Police, Brennan eventually returned to Sofia's home and was arrested in connection with murder and arson, but he was found to be unfit to interview. He was assessed under the Mental Health Act, detained under Section 2, and transferred to a secure Mental Health Hospital. On reassessment this changed to Section 3 for treatment for a mental disorder[42].

3. 110 At the first court hearing in the Autum of 2021 a plea was submitted by Brennan's defence of guilty to manslaughter and arson by reason of diminished responsibility and this was accepted. After a period of treatment with anti-psychotic medication, and then 6 months medication free with no ill-effects or relapse Brennan was judged to have been treated and he was moved to prison. However, there were two incidents of assaults on prison officers and a deterioration in his mental health. In August 2022 Brennan was returned to secure hospital.

3. 111 Sentencing took place in October 2022. Psychiatric reports for the court concerning Brennan agreed a diagnosis of Hebephrenic Schizophrenia[43] a dissocial personality

[42] Section 3 of the Mental Health Act is commonly known as "treatment order" allows for the detention of the service user for treatment in the hospital based on certain criteria and conditions being met. A patient can be kept in hospital for up to six months at first so that a patient can be given the treatment they need.
[43] ICD-10 Version:2010 - F20.1 Hebephrenic schizophrenia A form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and unpredictable, and

disorder and polysubstance misuse. He was sentenced to a Section 37 Hospital Order and a Section 41 Restriction Order under the Mental Health Act.

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 Sofia, and Brennan the person convicted of her manslaughter.

4.2. Sofia was known to primary and secondary Health services. She had been with the same GP practice for many years who were aware of her physical health needs, her developing physical frailty, and concerning her memory as she grew older. Her GP practice was also aware via a letter from her solicitor that Sofia had made a 'living will' known as an Advanced Healthcare Directive, in addition to Lasting Power of Attorney to her daughter and her friend and neighbour who was also her solicitor which included sharing relevant clinical information with her daughter. The practice had also been made aware that one of Sofia's younger sons managed her financial matters.

4.3. Following a brain scan and assessments by a consultant psychiatrist the Memory Assessment and Treatment Services was aware of Sofia's age related mild to moderate cognitive impairment in respect of her memory. These assessments were shared with her GP.

4.4. The Norfolk & Norwich Hospital held information about Sofia following her treatment in A & E for a fractured left arm following a fall at home. Reablement services via Norfolk First Support were made aware by Sofia's daughter of her needs and home aids to support her recovery after she returned home following a period of recuperation with her daughter were organised.

4.5. Private care providers appointed to provide domiciliary care for Sofia when needed clearly had information about her medication to ensure this was taken regularly, and her level of self-care abilities to provide support to enable her to be as independent as possible.

4.6. Adult Social Care held information detailing safeguarding concerns raised by some family members regarding Sofia's care. Sofia's views about the referral were requested by Adult Social Care and after one of her younger sons spoke to her on the phone Sofia's views that she did not want action taken, or the involvement of Adult Social Care were relayed and recorded by the service. As Sofia was deemed to have mental capacity no further action was taken.

4.7. Information held by services relating to Brennan once he left secondary school and of relevance to the Review began when the Police were called to the incident in May 2020 when he forced his way into Sofia's neighbour's home, assaulted his father, and had a verbal altercation with Sofia. Brennan was judged to be mentally unwell, and the Police involved the Mental Health Crisis Team. The Police were next involved with Brennan when he left Sofia's home in July 2020 and his father reported him missing. He was found, and as he was now an adult and was safe and well, his safety status only was reported to his father. There was very brief contact with the local authority Housing Department at this time, but support was not accessed. The next and final information held by the Police concerns the call from Brennan's father in December 2020 and officers attendance in relation to Brennan's behaviour reported by his father.

---

mannerisms common. The mood is shallow and inappropriate, thought is disorganized, and speech is incoherent. There is a tendency to social isolation. Usually, the prognosis is poor because of the rapid development of "negative" symptoms, particularly flattening of affect and loss of volition. Hebephrenia should normally be diagnosed only in adolescents or young adults. ICD-10 Version:2010 (who.int)

4.8. Mental Health Services held information relating to Brennan's first contact and assessment which resulted in his admission under Section 2 of the Mental Health Act. The Mental Health Professional's assessment included background including aggression towards his mother when 15yrs, also towards his father, and that his grandmother was anxious and scared of him; there had been a verbal incident with his grandmother. Further assessments were undertaken during his admission, his use of cannabis was noted, a diagnosis made, and medication prescribed which achieved a resolution of his psychotic episode prior to his discharge. The discharge summary recorded his risk to self and others as low. Admitting assessment information regarding verbal abuse of his grandmother and her being scared of him was not transferred into a discharge summary.

4.9. The Early Intervention Team involvement with Brennan following discharge was relatively brief: he had 5 appointments including a home visit and missed 3 appointments before he left for the University of Manchester. The team held background information from contact with Brennan and his father, provided Brennan with relevant documentation to enable him to be considered for extra support at university and provided information to his Manchester GP. Brennan's refusal to consent for information sharing with his father and contact with university student support service or Manchester Mental Health Services was recorded. After Brennan left Norfolk, the team became aware that he had not been accessing his Norfolk GP for repeat prescriptions as he claimed and was therefore no longer complying with his medication. The team made the decision to keep Brennan as an open case should he return to Norfolk. They were aware of Brennan's father's concerns about him at university and advised he contact the university's student support service. They became aware of Brennan's return to Norfolk in early December when his father contacted them citing no odd or concerning behaviours by Brennan, but unrealistic study options. Brennan was offered an appointment but the fatal fire happened before this could take place .

Other Relevant Information:

Sofia:

4.10. A friend who had known Sofia a great many years described her as a very independent woman for whom her children were her whole life. Education was also very central to her life; she believed education was important for her children and grandchildren, and she was very proud of all that her children had achieved.

4.11. Her friend reported that birthdays were important to Sofia, and she loved giving presents; she was a very giving person. In recent years health issues had limited meetings in person, but they kept in touch by phone, notably on birthdays, and they spoke on Sofia's last birthday. Her friend commented that Sofia's cognitive abilities were declining; she could sometimes get things muddled, but she was almost 90 years old.

4.12. To gain a further perspective of Sofia the chair spoke to the manager of the care service who provided support visits occasionally when her son went away. He explained that when care was requested, this consisted of two visits of 35 minutes per day, during which carers would ensure Sofia had a meal and took her medication. Personal care such as help with washing and dressing was not required. The manager himself undertook a number of the visits which were confined to the kitchen and living area, and during their visits there was no sign of clutter or hoarding in those rooms. As far as he was aware there was no one else in the house during visits; Sofia appeared to be alone.

4.13. At the first visit of the day at 9:00am Sofia was already up and dressed and would answer the door bell herself; she was suitably dressed and there was no evidence of self-neglect. The manager described how Sofia could be seen sitting in her chair by the sitting room window when he walked up the front path. In the house Sofia walked unaided, although a walking frame was available. In the manager's experience Sofia's mobility was good for

her age. The only other aid seen was a commode in her bedroom which was on the ground floor at that time. There appeared to be no downstairs toilet.

4.14. The manager observed Sofia to be very 'with it'. They had conversations about her early life in Sweden, her career, and exchanged information about their different cultures. Sofia even taught him to speak a little Swedish; she was well read and very interesting to talk to. The manager also noted Sofia spoke very proudly of all her children and their achievements.

4.15. Although not unexpectedly, carers visiting to support Sofia when she first returned home after breaking her arm described her as having poor mobility, needing prompting to take medication, and either reluctant or lacking in confidence to do much without aid, this changed as time went by, and the live in carers gradually saw improvements. In one of the later visiting carer's statements to Police Sofia was described as having very good mobility for her age; she could go upstairs unaided, get in and out of the bath by herself, and she did not use aids when walking about the house. One carer noted that Sofia's son tried to persuade her to stop having care, that it was expensive, and she did not need it. In this carer's opinion Sofia did need the care at that time and she felt that Sofia enjoyed the company. The carer believed Sofia loved her son who lived with her, but she found the relationships between her children difficult, she wished all her children would get along. She observed that Sofia did not wish to go against her eldest son, but she did not want to choose between her children.

4.16. Another carer had the impression that Sofia did not want carers, but her family were insistent. Her eldest son was concerned she would forget to have meals when he was away, and she found the microwave complicated to use. This is borne out by Sofia's daughter who described passing the house and seeing smoke; Sofia had put a metal container in the microwave while her eldest son was away. Her daughter informed the chair that she tried to persuade Sofia to come to her home but she refused saying her eldest son would be cross. Sofia's eldest son later purchased a microwave which was simpler to operate.

4.17. One carer observed that Sofia's son was very caring of his mother and appeared to have a good relationship with her. He expressed unease at doing personal care for his mother as a man and felt it would be better for this aspect of her care to be overseen by a female. However, it appeared to the carer that he was not always coping with the situation, and he seemed very anxious and stressed on occasions. To the carer it felt that Sofia's eldest son felt a great deal of responsibility for his mother and her care. There is no evidence that a carer's assessment was offered at any time by any professionals.

4.18. One of the daily visiting carers found Sofia very much enjoyed cooking in her younger life and this would often be a source of their conversations. Sofia refused personal care even though it was part of the care plan; one carer observed that Sofia was more capable than she was led to believe; she was mobile enough to do her own personal care upstairs. A carer commented Sofia's short term memory was not always good; she would forget the carer had been there that morning when they attended in the evening, and she would often forget to lock the back door despite being reminded. Sofia would talk about her eldest son, and she said it was a shame he had to go away for work. Whilst undertaking an assessment visit Sofia's son stated that there was a camera in the front room. The carer noted it was on a furniture unit pointing towards the doorway of the room; it did not have any visible lights. Sofia's son stated this was installed to check that his mother was okay during the day and had not fallen.

4.19. Observations by one of the live in carers who supported Sofia's recovery in the Spring of 2019 included that when they spoke to her they needed to raise their voice slightly and speak clearly to be heard as she was hard of hearing and Sofia was quietly spoken. Sofia liked to read a great deal. Her family would phone her regularly, but Sofia was a very

private person and did not discuss family relationships. Another relief live in carer described Sofia as a lovely lady who did not require much personal care; it was more a role of companionship.

4.20. Between June 2019 and March 2020, a care agency provided short daily visits periodically when Sofia's eldest son was away. They had been approached by her eldest son to provide this cover. When the care manager visited Sofia and her son to discuss her needs Sofia said she did not need care, she could manage herself. The manager explained to Sofia's eldest son that they could not provide care as she had capacity and stated she could manage without assistance. It is not clear from the statement whether Sofia was seen alone. The care agency was then contacted by Sofia's second son who requested visits when his elder brother was not there to cover meal times. One carer who attended Sofia in October 2019 returned in the December and her office relayed a message from Sofia's second son that she had deteriorated since, but the carer said she did not find that to be the case.

4.21. In a 2019 letter seen by the chair in which a solicitor confirms the content of their meeting with Sofia, it records that Sofia was having carers at that time as her eldest son was abroad, but she preferred him to be her carer on his return. Whilst Sofia had not envisaged needing extra care, she had acknowledged that if her health deteriorated in future and her eldest son could no longer meet her care needs, she had made it very clear she would pay for carers rather than go into residential care.

4.22. There is no mention of Brennan in Sofia's home during this time, even though he was recorded as returning to her home when he left school in June 2019 prior to going to Thailand after finishing school, or when he returned in March 2020 from Reading University.

Brennan:

4.23. Pre-sentencing psychiatric reports for the court included a suggested diagnosis for Brennan of "a psychotic disorder secondary to multiple substance use[44] (likely cannabis and cocaine)". Brennan admitted cannabis use over a number of years including when younger and living in Thailand. The psychiatric report states that such a psychotic disorder is precipitated by the use of illicit substances where the mental and behavioural effects exceed what people would usually expect from using those substances.

4.24. A psychiatric report of December 2021 included the observation that Brennan was understandably anxious about a custodial sentence and had repeatedly told his consultant psychiatrist that he wished to be in hospital rather than prison. Early in his admission he tried to search "how to get away with arson" and "how to get away with murder" during a supervised internet session with a member of the Psychiatric Team. Brennan had also tried to raise the prospect of dementia with the report psychiatrist when he reported that he could not remember setting the fire which he then could remember doing whilst in the secure unit. At this stage of assessment, it was the consultant psychiatrist's opinion that Brennan feigned psychotic symptoms in his interview with the admitting psychiatrist in Cheadle where he was briefly sent after arrest.

4.25. The December 2021 report for the court also found it difficult to assess if the challenging relationships Brennan had with his father and grandmother had any effect on his actions the night of the fatal fire. However, the consultant psychiatrist observed that at no point since he had been seeing Brennan had he expressed a wish that his father or grandmother would die.

[44] A condition categorised in the International Classification of Diseases 10th edition as F19.5.

4.26. The Addendum report for the court of March 2022 by the consultant psychiatrist who treated him in the medium secure hospital, offered the opinion that Brennan "retained little responsibility for his actions at the time of the offence due to a combination of the substances he had taken and the ensuing psychosis". However, as Brennan gave very limited explanation as to why he set the fire, his vague psychotic phenomena, his mental state in hospital following arrest, and his rapid improvement in mental state, the consultant psychiatrist felt he would not consider Brennan to retain no responsibility for his actions on the day of the offence. When Brennan was deemed successfully treated and transferred to prison in January 2022 the professional opinion was that he was able to take responsibility for his actions.

4.27. The psychiatric report noted information provided by Brennan's father that Brennan was violent to his mother in Thailand before coming to the UK, and this involved the use of a weapon (a BB pellet gun). The assault on a neighbour and his father, and Brennan's difficult relationship with his grandmother Sofia was also noted. However, in the time Brennan was in the medium secure unit he was not seen to be violent; he was more likely to be a victim of assault than a perpetrator (e.g., he tended to invade other's space and to stand in front of the television when other patients were watching which caused tension). He tended to annoy others or be irritable with others. It was the consultant psychiatrist's opinion that Brennan represented a risk of violence towards his family - but a risk to others when he was using illicit substances[45].

4.28. In summary Brennan was judged unlikely to have fully understood what he was doing at the time of the fatal offence as he had used illicit substance and seemed to have developed a brief psychotic illness as a result. This was the second instance of psychosis secondary to substance misuse (the first being the end of May 2020). Therefore, he was a low risk to himself and others if he stopped using illicit substances and his mental state remained stable. However, he was assessed to be at risk of aggression towards others (such as his father) but he had demonstrated an ability to restrain himself. For example, Brennan was assaulted without provocation when on the secure unit and he had not retaliated.

4.29. A further Addendum report of April 2022 was undertaken into the two assaults by Brennan in prison; one on a female prison officer and another on a male officer. The assessment was undertaken by his original consultant psychiatrist, a prison forensic psychiatrist, and prison support worker. The incidents involving the male officer were also reviewed by a second consultant psychiatrist. Brennan appeared more engaged and lucid than in the secure unit. He said he assaulted the female prison officer (she was hit in the head) and called a 'bitch' because she would not let him phone his mother. This officer had previously helped him complete the phone call request. He maintained that he had booked the call in advance. During interview Brennan spoke of "delusions", but no delusions were evident. He said he occasionally heard voices when on his own. The report explained this phenomenon (dissociation) can be seen in people with personality dysfunction. No psychosis was in evidence and none of the professionals present had concerns about his mental state.

4.30. The assault on the male officer in March 2022 was preceded by Brennan being spoken to about stealing other prisoner's clothing and a pair of trainers from their cells. He was told to return the trainers, but he would not engage with the officer. The following day Brennan was on the landing, he removed his clothing, turned them inside out and put them back on. He threw a tracksuit a prisoner had given him into the bin. The day of the assault Brennan refused to take part in mass Covid testing and was isolated in his cell. He refused to collect his meal when instructed, therefore an officer placed it on his bed. Brennan tried to push past the officer who put his arm out to prevent him leaving his cell. The officer then experienced a barrage of head-butts; a prisoner came to his aid pulling Brennan back into his cell. Prisoners then noticed the officer had a pen hanging from his cheek with which

[45] Addendum report March 2022 for the Crown court

Brennan had hit him. CCTV footage also revealed Brennan had repeatedly punched the officer in the ribs.

4.31. The second assessing consultant psychiatrist found no evidence that the two assaults were driven by psychotic symptoms. In his opinion "the incidents had a strong flavour of instrumental violence occurring when he was frustrated by refusal for his demands to be met". In the view of the psychiatrist, it was:

> "*difficult to say why such frustration arises, but it would be reasonable to consider that it is reflective of his underlying personality in terms of a low tolerance to frustration and impulsive behaviour in the aftermath"* The psychiatrist *"remained of the view that there may be a neurodevelopmental condition in addition",* but he was of the view that Brennan was responsible for his actions.

This finding caused a revision of an earlier assessment, and the view was that Brennan *"may reach the criteria for consideration of dangerousness as presenting a risk to the public".*

4.32. Following the assaults on prison officers Brennan was transferred to another prison where his odd behaviour raised concerns. He was treated with an anti-psychotic medication and returned to secure hospital. Based on changes and observations of Brennan in the period since his arrest his original consultant psychiatrist changed his diagnosis to hebephrenic schizophrenia, a dissocial personality disorder and polysubstance misuse. The second consultant psychiatrist having reviewed the developments concurred with this diagnosis[46].

4.33. The recommendation to the court of a Section 37/41 Hospital Order with Restriction was suggested rather than a hybrid order of secure hospital followed by prison when Brennan was stable following treatment as this would allow for long-term follow up with forensic mental health services. This was considered the most appropriate way to address Brennan's risk to the public.

Information of Note:

4.34. A carer who visited Sofia on occasions between November 2019 and January 2020, when her eldest son was abroad recalled an incident in her Police statement when the smoke alarm was activated. She had placed Sofia's dinner in the microwave and then went to sit with Sofia in the sitting room. After about 10 minutes a smoke alarm activated which the carer described as extremely loud; it also had a woman's automated voice repeating a message.

4.35. The carer rushed to the kitchen, she did not see any smoke, but the room felt very hot. She switched the microwave off at the wall switch in case this was the source of the heat and opened the windows in an attempt to stop the alarm. The automated voice said to locate the control panel, but Sofia did not know where the control panel was, and the carer could not find it or any smoke/fire alarms fitted to the ceiling. She also ran next door to see if the neighbours had a code for the alarm but there was no answer. After approximately 5 minutes the alarm stopped. This was the only time the carer was aware the alarm went off. This eventuality should have been covered in a briefing for carers to enable them to deal with the situation.

---

[46] In describing the path to Brennan's diagnosis, the psychiatric reports helpfully explain the development of a mental illness such as schizophrenia rarely follows the same path. Symptoms and speed of the illnesses development varies between individuals which affects the time in which their illness becomes clearer. The use of illegal drugs complicates diagnosis and frequently a condition which is put down to illegal drugs, later turns out to be an enduring illness such as schizophrenia. It was noted that Brennan's relatively young age suggests that his illness was still in development.

4.36. There was no Fire Service attendance, and it is not possible to confirm whether an alert was sent to Sofia's eldest son's phone whilst he was abroad. The carer's statement contains no record of a phone call to check all was well in the house. As Sofia's neighbours were not at home it is not possible to evidence that the sound level of the alarm would be heard inside their property.

5. Analysis:

5.1 This analysis aims to address the Review Terms of Reference and will thus be structured under the Terms.

Term of Reference 1: *The Review will identify and examine in detail agency contact with the victim and the perpetrator between mid-2017 when the perpetrator came to the United Kingdom to commence his A level education, up to December 2020. 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 This has been addressed within the combined chronology in section 3 and other relevant information section.

All Agencies:

Term of Reference 2: *Was either the victim or the alleged perpetrator assessed as an 'adult at risk' as defined by the Care Act 2014 which came into force on 1 April 2015? If not were the circumstances such that consideration should have been given to an assessment?*

5.3 To assist the reader's understanding of the definition of an 'adult and risk' and the statutory framework which underpins relevant processes the following information is provided. Under Section 42(a) of the Care Act 2014, enacted 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:

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

This has become known as the 3 point test which forms the statutory criteria requiring Local Authorities under Section 42(2) of the Act to:

iv. making (or causing to be made) whatever enquiries are necessary;
v. deciding whether action is necessary and if so what and by whom.

The objectives of a S42 enquiry into abuse or neglect are set out in paragraph 14.94 of Care and Support Statutory Guidance (DHSC, 2018):

- establish facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support, and redress and how they might be met
- protect from the abuse and neglect, in accordance with the wishes of the adult
- 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 the adult to achieve resolution and recovery

The duty to make enquiries under S42(2) is not a prescriptive process as it was prior to the Care Act but consists of activity to inform decision-making and the actions to be taken. This might include a new care assessment or care plan – or to take no action at all[47]. The process is also informed by the person centred 'Making Safeguarding Personal'[48] ethos. The main difference between the system for enquiries pre-Care Act and post-Care Act is that pre-Care Act safeguarding was not on a statutory footing and was covered only by the 'No Secrets' guidance. From 2014, safeguarding was enshrined in the Care Act legislation (S42 to S45), statutory guidance chapter 14.

5.4 A further crucial and important difference between the two systems relates to previous guidance emphasised the duty to report and act on all allegations of abuse, whereas the Care Act emphasises the empowerment of the person, their right to choose, and control how and with whom information is shared if they are deemed to have the mental capacity to make that decision. This may appear to be a weakening of the 'duty' to act on allegations of abuse, and it is arguable that the 'right to choose' fails to recognise and acknowledge the impact on a person's ability to exert self-determination in cases of domestic abuse and coercive control, even if they have mental capacity. Behaviours such as 'gaslighting'[49] often used as part of coercive control for example, can effectively diminish a victim's ability to freely choose, as of course can fear of repercussions if an agency becomes involved.

5.5 When Sofia was seen by the Memory Assessment Team between 2017-18, she was not considered to be an adult at risk and to have care and support needs as defined by the Care Act. She was living independently at that time and although she was assessed as having age related mild cognitive impairment, the level of impairment did not define her as an adult at risk; she was judged to have mental capacity consistent with the Mental Capacity Act at this time.

5.6 Adult Social Care had a 'preventative assessment conversation' on 1 March 2019 with Sofia's daughter following her discharge from hospital after treatment for a fracture following a fall. At this time Sofia required support with daily living and personal care and there was an "appearance of need" under the Care Act therefore Sofia received a period of reablement support prior to private carers being engaged. This was in line with the Act's wellbeing approach to include a focus on delaying and preventing care and support needs and supporting people to live as independently as possible for as long as possible[50].

5.7 Following Adult Social Care's receipt of a letter in June 2019 raising safeguarding concerns about Sofia (described in the chronology 3.37-3.42), a process commenced to establish whether the criteria in Section 42(1) of the Care Act were met. The service's IMR explains that on the basis of the information shared by Sofia's younger son who was asked to seek her views about her care, it was concluded that Sofia was not an adult at risk. A full discussion of the safeguarding enquiries process and decision making will be given under Term of Reference 14.

5.8 Brennan was assumed to have capacity to make decisions when well in line with the Mental Capacity Act (MCA), once he became unwell however he would require a capacity

---

[47] 'Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording' Local Government Association & ADASS, August 2019. Making decisions on the duty to carry out Safeguarding Adults enquiries (local.gov.uk)

[48] Making Safeguarding Personal aims to give more choice and control to the person, keeping them central to the enquiry, with a focus on improving their quality of life, well-being and safety. The key focus is to develop a real understanding of what the person wishes to achieve, recording their desired outcomes and seeing how well these have been met. Making safeguarding personal | Norfolk Safeguarding Adults Board

[49] Gaslighting is a form of psychological manipulation in which one person makes another person doubt his or her perceptions, experiences, memories, or understanding of events that happened. Gaslighting in Relationships: How to Stop It & What You Can Do (psycom.net)

[50] Care and support statutory guidance - GOV.UK (www.gov.uk)

assessment under the auspices of the MCA as he had “an impairment of the mind” i.e., mental illness, in respect of decisions related to all aspects of his life including his ability to manage his own affairs, accept care and treatment, and attend to daily activities of living. To note that unless assessed as otherwise capacity would be assumed despite mental illness.

5.9 Mental illness does not routinely mean a person has care and support needs as outlined in the Care Act, nor necessarily a person at risk of abuse as a consequence, however any assessment should consider that when unwell a person’s ability to care for themselves or keep themselves safe may be impeded, and action should be taken to offer support where needed.

5.10 Whilst at university no consideration was given to Brennan being an adult at risk as the information made available to the university, including through assessment of him by support staff, did not suggest that he was approaching their threshold to be formally assessed as such.

5.11 According to GP records Brennan was not assessed as an ‘adult at risk’ as he was not seen by any of the GP with whom he was registered after leaving school therefore this is not unexpected.

5.12 The Panel discussed the matter of Brennan’s use of testosterone whilst at school and considered this to be a safeguarding issue. His use of testosterone was disclosed by his father when Brennan was Sectioned at the end of May 2020 and this assessment noted that among the effects of the substance are irritability, rage, and anger. This issue was followed up with the school who reported the original concern was not raised internally with the school's safeguarding team. Instead, the school shared their concern with Brennan’s parents via email. The school's current safeguarding lead was not in post at the time but the Panel was given assurance by the school in June 2022 that they now have clear safeguarding reporting procedures relating to drugs/medication, whether prescribed or illegal.

5.13 Reflecting on Brennan’s parents use of B & B type accommodation arrangements during school holidays, this raises concerns regarding what steps they took to ensure the host or host family was suitable. It has not been possible to establish where these lodgings were located; Brennan’s father confirmed he did not know as his former wife, Brennan’s mother, made the arrangements from Thailand; there is no evidence the school were contacted regarding suitable holiday accommodation. The school rightly checked with Brennan’s father where Brannan was staying in the school holiday and whether the guardianship arrangements for Brennan remained correct in March 2019. However, there is no record that they received exact details of where Brennan was staying when not staying at his grandmother’s; they were simply told Brennan wanted more independence hence his mother was arranging accommodation, but his grandmother remained his guardian when his father was abroad. During school holidays Brennan was the responsibility of his father and guardian when in the UK. Brennan’s father reports he tried to facilitate relations with the school, and he insisted that Brennan's mother inform the host family that Brennan was under 18 and to get written confirmation (text or email) that the host family agreed to act as a 'host' for Brennan for the duration of his stay as a condition for staying with them. On occasions he did pass on details to the school, but communication was primarily to be with Brennan’s mother. Brennan’s father reports he did not see Brennan after the first day while he was at school.

5.14 The Police work to a definition of an ‘adult at risk of harm’ as follows:

A person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) Personal characteristics which may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. and/or
b) Life circumstances which may include, but are not limited to, isolation, socio-economic factors, and environmental living conditions

5.15 Following the incident in May 2020 to which the Police were called initial risk concerning Brennan was assessed within the MASH. As risk was deemed to be managed via the Mental Health Crisis Team and subsequent admission to hospital, no onward referral to Adult Social Care as an adult at risk was necessary. Sofia was also not considered for referral as she did not appear to be involved in the incident. She was noted as being in the living room and as not having witnessed events. Brennan's father was the only family member recorded as present and there were no recorded concerns by him relating to his mother.

5.16 Neither Sofia nor Brennan were considered to be 'adults at risk' during Police attendance at the domestic abuse incident in December 2020. Sofia was not seen by officers; Brennan's father had indicated that she was in her bedroom and said she could not hear anything. Although he had said *"he could kill; he could do anything to us; he is not stable. I can hardly sleep at night now",* Brennan's father did not raise any specific concerns about Sofia. Nevertheless, it is clear from his words that he was anxious about his personal safety; it would have been good practice for officers to probe further regarding Sofia, for example to establish whether conditions named in the 'adult at risk' definition above might be applied; age, frailty, and hearing impairment were relevant. Also, to ascertain for themselves what Sofia's relationship with Brennan was like, and to check that she was safe and not distressed by any commotion during the dispute by Brennan with his father (his behaviour was described to the chair as aggressive by Brennan's father). Officers are expected to see vulnerable children when they attend a domestic abuse incident, the same should apply to vulnerable older adults such as Sofia.

5.17 Brennan was not considered an 'adult at risk'. Compared to the two officers' contact with him in May 2020 when he was agitated and his behaviour clearly indicated he was mentally unwell to the extent he was Sectioned, on this occasion he was calm and quiet (confirmed in body camera footage). A referral was made to the MASH however, to make Adult Social Care and Mental Health Services aware of the incident.

Term of Reference 3: *Did Sofia, or close family members, ever express unhappiness or concerns about the perpetrator being in her home to anyone involved in her care, and if so, what was done with the information or what action was taken?*

5.18 One of the clearest indications that Sofia was unhappy with Brennan staying in her home is represented in the incident which took place sometime in early 2018 when she suddenly arrived at her daughter's home with a suitcase distressed by his behaviour and wanting him removed. Brennan's father was contacted to deal with the situation. Apart from Brennan's father none of the family knew Brennan was staying in Sofia's home, and after this incident the understanding was that he would not do so again.

5.19 On 2 July 2020 Brennan's father reported him missing to the police. The Police record notes there had been an argument with his grandmother about him smoking 'weed' and she had asked him to leave. This demonstrates that Sofia was unhappy about Brennan being in her home. This incident had been relayed to the Police as an explanation for why Brennan may have left.

5.20 When Brennan went to see a housing officer on 3 July 2020, he stated that he had been asked to leave by his grandmother after an argument about his smoking. Thus, Brennan himself was aware at that time that Sofia did not want him in her home, and this was recorded by the housing officer.

5.21 The housing officer spoke to Brennan's father who explained he was the carer for his 88 year old mother (Sofia) and that his mother did not remember what she had said and not aware of the consequences of her decisions. He confirmed that Brennan had mental health issues, and his contact with the Police and the Mental Health Crisis Team. The housing officer asked to speak to the home owner which was good practice. However, Brennan's father relayed that he had spoken to his mother (Sofia) and Brennan could return home. Brennan was advised of this. It would have been further good practice to insist on consulting Sofia independently to ensure that she was freely consenting to have Brennan return given that she, as the householder, had been the person asking him to leave.

Recommendation:
Local Authority Housing Departments when making enquiries to establish the status of a homeless applicant claiming to have been excluded from home, should ensure that the person said to have excluded them, and/or the accommodation owner should be spoken to independently to confirm whether they freely agree for the applicate to return, or to confirm they are excluding them.

5.22 As far as the carers who supported Sofia when Brennan's father was away were aware, there was no one else in the house during their visits. Their morning visits were of short duration (30-45 minutes) therefore Brennan could have been in his room unknown to them, but he was also at university during term times.

5.23 Although not directly expressed by Sofia to a practitioner, during the gathering of information for the Approved Mental Health Professional (AMHP) assessment on 31 May 2020 information recorded from Brennan's father included that Brennan had a strained relationship with Sofia and he had a phobia about her; what this entailed does not appear to have been probed; no detail is recorded. Brennan did not want to return to Sofia's house, and his grandmother was anxious and scared of him. This is the clearest indication that Sofia was unhappy to have Brennan in her home at this time. The assessment report contained this and other useful information. It was then stored on the appropriate data bases and shared with the hospital to which Brennan was admitted under Section 2, This report will be discussed further under Term of Reference 5.

5.24 As previously mentioned, the Police did not speak to Sofia during their visits to her home. Brennan's father was the person expressing the wish that Brennan was removed at one point stating to officers he wanted him removed because he *'could not do anything with him'* and he was fearful of him. This will be addressed in detail in the specific Police Term of Reference 28.

5.25 There is no record of Sofia being consulted in person by any professional about Brennan living with her or returning to live in her home when he was discharged from hospital. The Early Intervention Team care coordinator visited to see Brennan and his father, and it is reported no concerns in relation to Sofia's needs were raised. However, although the care coordinator only saw Sofia once fleetingly in the hallway of her home, she was not spoken, the care coordinator did not introduce themself, nor was Sofia invited to be included in the home visit meeting. This was impolite and a discourtesy to Sofia. The report explains the care coordinator was aware that Brennan had pushed past Sofia's neighbours when in a psychotic state thinking that people were trapped inside, but no concerns were raised about Sofia, either by Brennan or by his father, and Brennan's risk assessment post discharged showed 'low' risk in all areas. This begs the question what had happened to the information described in the AMHP assessment report regarding Sofia being 'anxious and scared' of Brennan?

5.26 Sofia's GP had no record of Sofia or close family members expressing unhappiness or concerns specifically about Brennan being in her home. No such concerns were shared with the University of Manchester attended by Brennan.

Term of Reference 4: *Had the individual practitioners in contact with Sofia to provide care and support, or involved in decision making about safeguarding, undertaken the following training:*

a) Domestic abuse training (state duration and content of the training)
b) Adult family 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) 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 elder abuse in a domestic abuse context. If not, identify the practitioner's gaps in their training needs?

5.27 The University responded to this Term of Reference that this question is not relevant to the University of Manchester. Whilst recognising that their involvement with Brennan may not have raised issues around domestic abuse, the University should recognise that intimate relationships between students are not immune from domestic abuse and/or coercive and controlling behaviours. The University runs a module for new students which includes 'healthy relationships', therefore indicating that the University has considered the need for such awareness raising.

5.28 The GP practice IMR reports prior to Covid-19 restrictions domestic abuse training was an annual half day event; training is now online and lasts for 1½ to 2 hours. Individual training plans have been established for all GP's and staff delivered online via a Team Net e-learning module. The IMR author could not access this e-learning to clarify the content, however. Combined with safeguarding training, which includes domestic abuse, it is the practice's view that their training meets their needs in terms of the skills required to identify domestic abuse, including adult family abuse. It was acknowledged however, that due to the impact of Covid over the last 2 years, further training for staff is needed. GPs and other practice staff last received adult family domestic abuse training on 25 February 2022 presented by the county's domestic abuse service Leeway. Training is supplemented by quick links to an NHS online information site called Knowledge Anglia which provides access to relevant resources. This includes asking about domestic abuse, information about Leeway domestic abuse services, and best practice guidance on responding to domestic abuse and violence in primary care provided by the domestic abuse charity Safelives. https://safelives.org.uk/best-practice-responding-to-DA-in-primary-care . However, training for GPs is not mandatory, it is often of short duration, fitted into lunch breaks due to work pressures, and locum doctors are not covered. A health panel member believes this is a national level issue, hence a recommendation is made.

Recommendation:
That NHS England examine the efficacy of mandatory dedicated domestic abuse training for all GPs as part of their continuing professional development to enable them to keep up to date with all aspects of domestic abuse. If possible, training time should be protected to enable GPs to attend.

5.29 The Mental Health Trust IMR confirms all level 3 clinical staff undertake a mandatory domestic abuse course every 3 years which includes coercive control, honour-based

abuse, and elder/carer abuse. There is also refresher training on DASH[51] and MARAC[52], the role of independent domestic abuse advocates (IDVAs) and support agencies. The aims of the training are to raise awareness of the impact of domestic abuse and for staff to gain confidence in identifying and responding. Also mandatory is adult safeguarding training for all level 3 clinicians which includes Section 42 of the Care Act referral and investigations. Practitioners believe their training is sufficient, however, the IMR observed a learning point for the Trust to strengthen awareness of the impact of domestic abuse for all people in the family, not just children. The IMR makes a recommendation in respect of this learning.

5.30 The IMR for Adult Social Care confirmed that as a category of abuse in the Care Act domestic abuse and coercive controlling behaviour are embedded in safeguarding adults courses which were recently updated to include a greater focus on these issues. The training covers the definition of domestic abuse, range of perpetrator behaviours, impact on victims, and steps to take following a disclosure of domestic abuse. Making Safeguarding Enquiries is a 2 day course, Safeguarding Basic Awareness is a half day course. Current domestic abuse and coercion and control training is a half day course. During a jointly funded beacon site partnership programme with SafeLives between 2016 and 2021, Adult Social Care staff had access to training provided by SafeLives on trauma informed practice and the whole family approach. DASH training is also available,

5.31 The training lead for safeguarding has sought assurance from the training provider that the content of the courses set by Norfolk County Council continues to be delivered as requested. The training lead sometimes attends courses as part of the quality assurance process. A higher level course "learning lessons from Safeguarding Adults Reviews" is now to be called "learning lessons from Safeguarding Adults Reviews and Domestic Homicide Reviews" and will have a heavier focus on domestic abuse. The Making Safeguarding Enquires course will cover making a safe enquiry when domestic abuse is an issue. All courses will address how coercive control may affect a person's capacity to make decisions about their safety and what to do if the person is at risk of harm. At the time of writing the IMR a specific standalone course for all staff on domestic abuse and coercive control has been commissioned which is mandatory.

5.32 Community Health & Care staff training depends on the band level of the staff. Unregistered staff at Bands 2-4 undertake mandatory level 2 safeguarding adults training delivered by Health Education England and contains basic level domestic abuse awareness training. Completed every 3 years it is of 2 to 3 hours duration. From 2019 registered staff at Bands 5 and above are required to undertake level 3 full day safeguarding training, however the domestic abuse section which participants complete takes just approximately 20 minutes to complete. The IMR confirms this section includes content on: Definitions of domestic abuse (as per the Domestic Abuse Act 2021); definitions of coercive and controlling behaviour; the Duluth Power and Control Wheel; Norfolk Safeguarding Adults Board 7 minute briefing on Domestic Abuse; a scenario exploring the Power and Control Wheel, having conversations about domestic abuse with patients/victims, making safeguarding personal; local domestic abuse champions. Training on adult's at risk and referring safeguarding concerns to the Norfolk Multi Agency Safeguarding Hub (MASH) included. Covering such a range of domestic abuse issues in just 20 minutes appears to be highly ambitious and would suggest a challenge not only for the trainer to deliver, but also for the attendees to absorb.

5.33 The only specific domestic abuse training is for domestic abuse champions. This is a two day training course giving staff enhanced knowledge on identifying domestic abuse,

[51] Domestic Abuse Stalking & Harassment (DASH) – an evidence based risk assessment undertaken to assess the risk faced by victims of domestic abuse.

[52] Multi-Agency Risk Assessment Conference (MARAC) – a multi-agency meeting to share information and safety plan for victims of domestic abuse who are assessed as at high risk of harm.

completing a DASH Assessment, MARAC, and how to support and signpost staff, patients and victims to information and advice on domestic abuse. None of the professionals involved in the care of Sofia, were identified domestic abuse champions.

5.34 All Norfolk Constabulary frontline officers and detectives receive mandatory training on controlling and coercive behaviour, stalking and harassment, and the risk assessment process for domestic abuse, in addition to other aspects of domestic abuse. To improve investigation standards all sergeants supervising investigations receive additional training with a focus on evidence led investigations. Officers also receive training on adult abuse.

5.35 Relevant to this Review, the Police IMR explained that student police officers receive mental health input during their 10 week initial training. This is primarily focussed on the least restrictive pathways to accessing mental health support and mental health legislation namely, Section 136 and 135 of the Mental Health Act (used in May 2020 when Brennan was mentally unwell), and the Mental Capacity Act. They receive input from the Mental Health Advice Team about their service, how they can support officers, and the more common mental health conditions. In October 2019 the Constabulary introduced a mandatory training day for front line officers focussing on mental health requirements set out by the College of Policing. This training had to be postponed during Covid. Whilst this training is clearly required to help officers cope with incidents encountered where mental health may appear to be a component, it does not replace the specialist expertise provided by mental health professionals to identify mental illness. Hence officers call on Mental Health Services where concerns arise as they did for Brennan in May 2020.

5.36 As can be seen, domestic abuse training varies between services. Early discussions at the DHR Panel identified a need for a strategic review of training provision and content within the county and this is included in the Early Learning section of this report. Although action started to review training early in this Review process a recommendation has nevertheless been made to monitor progress and keep this on track.

Recommendation:
Domestic abuse training which includes intimate partner abuse and adult family abuse across the whole age range, and includes the impact on children, should be of a consistent content and standard, and mandatory for all public facing staff (*full details appear in the Recommendations section of this report).* As is expected when children are present at the scene of a domestic abuse incident, training should include the need to check on the wellbeing of vulnerable adults in the household.

Term of Reference 5: *What risk assessments did services in contact with the victim or perpetrator undertake in the course of their involvement? Including:*

a) Was the risk assessment fully informed by an assessment of the victim's home environment, the standard of care provided to her, and include consideration of the other occupants in her home including the perpetrator?
b) Was the risk assessment reviewed and updated in response to changing situations or information?
c) 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 cases.

Adult Social Care:

5.37 The safeguarding concern raised by Sofia's younger son with Adult Social Care in June 2019 did not result in a formal risk assessment. There was no qualified practitioner's assessment of the home environment or professionals' checks made regarding the standard of care provided to Sofia; she was not seen in person and no enquiries were

made with her care providers or her GP. Whether the data system was checked for previous knowledge of Sofia is not stated or recorded; checking would have indicated Sofia's physical frailty after a fall for which she received support services in March 2019. Had Sofia's GP been contacted they would have been able to confirm that Sofia's daughter had spoken to them on 18 June also reporting her concerns about Sofia's care and being controlled by her eldest son.

5.38 As referenced previously Sofia's eldest son reported to the chair that he strongly contested the allegations made against him, and maintains he was doing all he could to care for Sofia as he was aware how strongly she felt about remaining in her home and not going into residential care.

5.39 The service's Individual Management Review (IMR) explained that no formal risk assessment was undertaken as initial enquiries led to the view that abuse was not occurring. This was assumed as it was noted Sofia had stated to her younger son who made the safeguarding referral, that she was being cared for adequately by her eldest son and she did not wish any Social Services involvement. The IMR adds that the care agency who provided occasional care for Sofia raised no concerns with Adult Social Care about abuse or neglect independently, but they too were not contacted to ask for their views, nor were other family members even though their contact details had been provided. Thus, there was no triangulation of information to check the veracity of the referral, and a lack of professional curiosity to probe further.

5.40 A PowerPoint slide in safeguarding training shows a template call 'Recording of risk on LAS' (LAS is the database used by Adult Social Care). This is not an actuarial risk assessment tool such as the DASH risk assessment for assessing level of risk. For example, the first column entitled 'Risk' asks 'What is working well?/What could go wrong?' rather than providing an evidence based aide memoir to support practitioners identify abusive behaviours to assess level of risk as with the DASH. Such tools augment experienced practitioners' own professional judgement. Given the safeguarding concern was within the family context and thus fell into the definition of domestic abuse, the DASH risk assessment could have been considered to guide the assessment of risk at an early stage. For example, when assessing an offender, the Probation Service uses a standard information and management template, but if domestic abuse is identified the assessments switches to their internal domestic abuse risk assessment tool called SARA.

5.41 Whilst it is recognised that the DASH is not a perfect tool for risk assessing older victims of adult family abuse (there are some questions which are irrelevant), it is nevertheless helpful in concentrating the focus on the types of abuse which may take place in cases of family abuse within the home, plus perpetrator behaviours, and adaptations to the DASH are being made in various parts of England and Wales to provide a greater focus on specific risks faced by older victims. A recommendation has been made concerning this matter.

Approved Mental Health Professional[53]:

5.42 The Approved Mental Health Professionals Mental Health (AMHP) Act assessment report undertaken in May 2020 identified important and concerning information in the 'social networks and social circumstances' section which included Brennan's father's report about Brennan's strained relationship with his grandmother who was described as anxious and scared of him. The 'reason for referral' section also mentions the incident of Brennan

[53] Approved Mental Health Professionals are mental health professionals who have been approved by a local Social Services Authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating your assessment and admission to hospital if you are sectioned. They may be: social workers; nurses; occupational therapists; psychologists.

forcing his way into the neighbour's house in which the neighbour was slightly injured, damage to Sofia's home and punching his father in the face.

5.43 The AMHP report section entitled 'risk assessment, including positive risk-taking' reiterates the information about Brennan forcing his way into the neighbour's, the slight injury sustained, assault on his father by punching him in the face, damaging a door, and throwing a mobile phone away bought for him by his father. It adds a 'further verbal incident' with his grandmother (linked to when Sofia entered his bedroom when he was on the computer). Sofia being anxious and scared of Brennan is not included in this section. The words 'Risk to others' appears next under the text, then 'Denied any thoughts of self-harm or suicidal thoughts or intent'.

5.44 The layout of the report template could be improved if the location of the risk assessment section was (a) on the last page in the 'Outcome' section underneath the 'AMHP decision' section. (b) risk assessment would be clearer if it had a separate 'risk to others' and 'risk to self' section, and (c) 'risk to others to be reassessed before discharge including to occupants of location to which being discharged'. This important 'Outcome' section could have a background colour to make it stand out for those who need this vital report during the treatment of the service user. These small changes would make the risk assessment more visible and reinforce the AMHP's professional assessment.

Recommendation:
That the AMHP report template be updated to improve visibility and clarity of the risk assessment section with the aim of making this vital information plainly visible to clinicians throughout the patient's journey in Mental Health Services both hospital and community based. Risk to self and risk to others should be in separate text sections.

The Mental Health Trust

5.45 The Mental Health Trust uses a combined assessment/risk assessment tool based on the Royal College of Psychiatrists guidelines. Brennan did have a risk assessment undertaken using this system. Sofia did not when seen for assessment at home for her memory as she was living independently at that time and no issues of concern arose at the time.

5.46 The Trust IMR is transparent in its finding that the risk assessment for Brennan is below the standard they would expect. He was seen face to face on his own on four occasions one of which was an ad-hoc contact as Brennan was in the area of the Early Intervention Team, and he was seen once with his father. He missed two appointments and cancelled one however and had not fully engaged with the Early Intervention Team before leaving for Manchester. Although there followed a number of phone conversations with Brennan, this impacted on the Team's ability to get to know him well.

5.47 The IMR found limited evidence of the service user's perspective or words being integrated into the document. The crisis and contingency plan sections were not completed, but there was generic guidance within other sections. The safety assessment was not completed, again due to the very limited contact with Brennan. As is noted in other assessments Brennan was a man of few words, especially in meetings where his father was present, and this alongside so few meetings may have affected the completion of the documents. Other case notes are of a good standard, completed in a timely manner, and show a good understanding of Brennan and the risks presented. The IMR suggested that the shortcomings in the paperwork did not contribute to Brennan's actions on his return from Manchester.

5.48 The Trust IMR explains although assessment tools are used it is the training, skills, and experience of the staff which provides the ability to undertake robust assessments.

However, the staff do report a desire for additional and targeted training on safety planning, including for the wider social network around service users who may pose a risk to others. Where this relates to family situations which come under the definition of familial domestic abuse learning from the experience of IDVAs in safety planning for victims could be beneficial for mental health staff. The author is aware of at least one Mental Health Trust which has an IDVA based within their service to increase their effectiveness handling cases involving domestic abuse.

5.49 The Mental Health Homicide Review suggested that "although the care coordinator did not believe there were risks concerning Sofia, and although there is no sense in which risks associated with abuse or neglect should automatically be identified solely on the basis of age, or memory problems, the Mental Health Homicide Review team considered it would nonetheless have been appropriate to complete a safeguarding form to ensure that checks had been made, and a recommendation has been made to this effect in their Review.

5.50 Following Brennan's in-patient treatment under Section in June/July 2020 the hospital discharge planning included a template in which risk was noted. Covering a variety of subject areas this included risk assessment of violent or aggressive behaviour – verbal or physical as low. Perhaps rather optimistically risk of drug and alcohol misuse was also assessed as low. The accuracy of this risk assessment would clearly be contingent on Brennan complying with his medication since this was the risk assessed at discharge following treatment with medication to eradicate his psychotic symptoms. Resuming drug use was also an identified risk at discharge. As with all risk assessments their validity is time limited; changing circumstances require reassessment of risk. Admittedly there was a 3 month gap between Brennan leaving for Manchester and returning unexpectedly to Norfolk, however, the Mental Health Service knew he had ceased taking his medication after he left, and whilst offering him an appointment when contacted by his father, it would have been wise to review the records of his previous behaviour when unwell and be more proactive on the basis of his aggressiveness to others at that time.

University of Manchester

5.51 No formal risk assessment (i.e., using a recognised risk assessment methodology) was conducted by the university with respect to Brennan. However, the chronology has detailed the considerations that informed decisions. Discussion regarding steps taken by the university are within the specific Terms of Reference for the University of Manchester.

Norfolk Constabulary

5.52 No risk assessment for Sofia was undertaken as she was not seen by officers, and she was not viewed as a victim at each of their attendances; Brennan's father said she had not seen or heard anything. Despite Brennan's father being identified as a victim in both the May and December 2020 callouts, and both being correctly recorded as domestic abuse incidents, no DASH risk assessment was undertaken with him as the Constabulary does not use the DASH risk assessment for familial abuse incidents. The Adult Protection Investigation process is used which involves professional judgement. This is discussed further under Term of Reference 20. Two risk assessments took place when officers had contact with Brennan in May 2020 which were judged as 'high' based on his mental health at the time following which he was Sectioned. A third risk assessment in December 2020 included in the free text record:

> *'Brennan suffers from mental health issues and has a hostile relationship with both of his parents…. Brennan is now having the same hostile relationship with his father, to the extent that father now wants him out of the house. Brennan allegedly has no other family in this country to move to, so he has to go to the council for accommodation. As well as being vulnerable due to his mental health, Brennan is*

also hyper intelligent so is allegedly able to convince doctors and mental health assessors that he is fine and discharge himself from any help."

The Police IMR confirms risk assessments relating to Brennan were updated in response to changing circumstances. These are based on free text input and officer assessment at the scene. Initial risk assessments are later reviewed within the Multi-Agency Safeguarding Hub (MASH) with onward referral considered and completed if required.

5.53 As can be seen, risk assessment differs according to agency. Consistency when addressing familial domestic abuse, particularly in the older age group, would greatly enhance services' safeguarding response and support practitioners in their assessments.

Recommendation:
To reduce risk in adult family abuse cases it is strongly recommended that a task group is set up to investigate the use of the DASH risk assessment tool by services when a safeguarding concern involves an allegation or risk of abuse within the family context which therefore meets the definition of domestic abuse. Where the safeguarding concern is about an older adult a suitably adjusted DASH designed for older victims could be used e.g. The All Wales Risk Identification Checklist (RIC) for MARAC Agencies or Cambridgeshire & Peterborough MARAC Referral Form and Risk Indicator Checklist for Older People (over 60).

Term of Reference 6*: What was the impact of Covid-19 and the restrictions put in place by the government in March 2020 on service provision and the ability of services to support the vulnerable of society such as Sofia?*

5.54 Government restrictions due to the Covid 19 pandemic began on 20 March 2020 with the closure of public venues such as cafes, bars, cinemas etc. This was followed on 23 March by the requirement that all people were to stay at home except for very limited purposes. Regulations were strengthened on 26 March by giving the police powers to enforce social distancing. The first lockdown was not lifted until 15 June 2020. Lockdown was reimposed on 5 November until 2 December 2020, although some highly infected areas maintained some restrictions post this timeframe.

5.55 Sofia's contact with services was before Covid-19 emerged. The last time she had contact with her GP surgery was on 31 October 2019 followed the occasion of her daughter raising concerns about Sofia's health with the NHS 111 service, and their contact with Sofia and her eldest son. Following this Sofia's eldest son requested a home visit and she was seen by the home visiting service. Sofia had a routine blood test on 22 November 2019 during a home visit by a district nurse and she would have had another sometime during December 2020 had the fatal fire not caused her death.

5.56 Travel restriction in place due to Covid prevented Sofia's eldest son from travelling as he had needed to do on previous occasions; therefore, the services of carers was not required at this time. The lack of external carers was a protective factor regarding Covid infection for Sofia at this time. However, it is debatable whether Reading University should have allowed students to leave as Brennan did during lockdown restrictions when he returned to Norfolk in April 2020, and whether it was safe for Sofia for him to return to her home. We know she had various health vulnerabilities including asthma which was an additional risk factor for a serious outcome if Covid was contracted.

5.57 Despite the risks and restrictions, at the end of May 2020 the Police and Mental Health Services took the necessary steps during Brennan's first psychotic episode to ensure he was placed in an appropriate hospital for treatment and the public were protected. Organisations put in place plans to protect their staff, e.g., Police used PPE, social distancing, and assessed risk to officers and occupants in properties visited to reduce spreading the virus. This impacted on Police practice with vulnerable groups notably those

over 60 years of age who had been identified as the demographic at particular risk. Officers visiting Sofia's home all wore masks and gloves. However, the Police IMR reports that officers did not state that Covid impacted on their decision making with regard to seeing Sofia, it was more affected by the fact that Sofia was thought to be sleeping and under the circumstances it was felt unnecessary and may have caused her distress. This is understandable given Sofia's age, and she did have health issues, however, checking on her wellbeing and seeking her views could have been undertaken carefully and in a socially distanced manner.

5.58 During the time Brennan was attending the University of Manchester Covid-19 restrictions were in place. These were strictly enforced; the city had one of the highest infection rates at one point to the extent this was reported on the national news at the time. Procedures were put in place which meant when students in halls of residence reported a positive Covid test they received an email about isolating which set out practical advice in terms of accessing food and support. Other students in the hall of residence were also sent the same information as they were required to self-isolate until a negative test result was received. The residence team tracked positive cases and which students/flats were self-isolating and where this was the case the team would check in with residents to see if they required additional support or information.

5.59 The University had a dedicated self-isolation support website with information and practical support for students required to self-isolate. Working in partnership with the Students' Union the University developed the support available to self-isolating students in halls during the first few weeks at the start of the academic year. Additional support included the introduction of a postal delivery service, and a 99p fee supermarket delivery service. There was a dedicated team email address to answer questions about self-isolation and organise additional support.

5.60 When Brennan left Manchester and returned to Norfolk on two occasions in December 2020, he was leaving a highly infected area and at least one visit was during the heightened lockdown period. He appeared to have no consideration of this and the risk his travelling and arrival at Sofia's home would place on the public, and particularly his frail grandmother.

5.61 The impact of the Covid pandemic affected the options available to remove Brennan from Sofia's home in December 2020 when police officers attended. Hotels in the area were not available; they were either closed or being used to house people who were homeless to protect them from risks posed by the virus. At the beginning of December 2020, the second lockdown ended after four weeks and England returned to a three-tier system of restrictions which stipulated hospitality venues must close, except for delivery service, and hotels and other accommodation providers must also close, except for specific work purposes where people cannot return home. In mid-December Christmas rules were relaxed but the public were urged to keep celebrations "short" and "small". Previously in July 2020 Brennan had booked into a local hotel and stayed in a B & B when Sofia told him to leave. This was not an option in December 2020.

5.62 A study of 154 domestic homicides into the effects of Covid lockdown on levels of domestic homicide for the year ending March 2021[54], found parricide domestic homicides i.e., against a parent (or grandparent but not specified in the research) experienced higher pre-COVID levels at different points during the first, second and third lockdowns, rising to the highest levels in November 2020 and March 2021. According to the research data, there was a 7% increase of cases linked to the mental state of the suspect in the year ending March 2021 compared to the previous year (41% vs 34%). This fits with earlier research

[54] Amy Nivette & Abreu, V. (2023) Changing Patterns of Domestic Homcide During Lockdown: Interrupted Time-Series Analysis in England & Wales. *Homicide Studies pp1-24* Changing Patterns of Domestic Homicide During Lockdown: Interrupted Time-Series Analysis in England and Wales : University of Derby Repository

on domestic homicide[55] which revealed a contributing factor for adult family homicides during the pandemic included disrupted mental health or drug/alcohol support available to the suspect, or the suspect being discharged into the care of their family members, disproportionally affecting those who were already vulnerable.

5.63 The Police IMR also considered whether action could or should have been taken regarding Brennan's travelling between Manchester and Norfolk at a time of Covid restrictions. The IMR states:

> *'Consideration has been given to 'The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020 and any potential breaches associated with Brennan having attended the address in December 2020. COVID related regulations changed frequently and the constabulary approach towards enforcement has been to use it only as a last resort. Given the circumstances of the situation at the address, if there had been any breach of the relevant regulations in force at the time there would not have been an arrest. Engagement and explaining was the Norfolk Constabulary approach in these cases, only escalating to arrest in the most serious of circumstances'.*

Term of Reference 7: *Did the perpetrator's ethnicity or cultural heritage affect the following?*

a) Impact on how services were provided and if so, what steps were taken to mitigate this?
b) How he interacted with services or how he may have made decisions?
c) Were these factors taken into consideration in any assessments?

5.64 In the opinion of the Mental Health Homicide Review there is 'no doubt that Brennan's circumstances, his cultural heritage, and the challenges he faced in moving from Thailand, speaking a new language, and making friends had an impact upon him. It is likely that he experienced the move to England to his new family as stressful – possibly one reason that he continued to use cannabis'. The team's examination of clinical records and interviews with staff confirm that this was discussed with Brennan along with the difficulties he purported to be experiencing with his father. As noted elsewhere in this report, Brennan was found by staff to be relatively uncommunicative; interactions could not have been easy; he did not find it easy to talk about his state of mind. This may also have been due to cultural influences on how mental ill-health is perceived as described in paragraph 1.49.

5.65 The Mental Health Homicide Review found Brennan had made friends at boarding school some of whom he kept in touch with when at the Early Intervention Team. They were mostly young people who shared Brennan's interest in online gaming. The team believes NHS staff did what they could to mitigate the impact for Brennan of the circumstances of his translocation and any cultural `shock' that may have been exacerbated when he moved.

5.66 The university report that the mental health nurse who spoke with Brennan is not of white British heritage and when contacted by the IMR author for comment they were of the opinion that they felt more attuned to students from international backgrounds than some other practitioners might. They also assessed during the consultation that it was very clear that Brennan understood what was being said and was able to articulate his responses clearly. The Residential Life Team also had no concerns about two-way communication during their interactions with Brennan.

[55] Hoeger, K et al (2022). Domestic homicide project spotlight briefing# 2 older victims, cited in Nivette A & Abreu V (2023) above.

5.67 Brennan would not have completed any formal assessments of his spoken or English comprehension at any point as he applied for university as a home rather than an overseas student and as such was not required to demonstrate English language proficiency. Although frequently referred to as monosyllabic and difficult to communicate with, Brennan's English was reported as good and he did not require an interpreter at any time, including during his criminal trial.

5.68 Brennan was in a self-catered hall of residence and so was responsible for providing all his own meals, thus in a large city like Manchester he would have been able to source a variety of international foods. With respect to Covid restrictions, access to food, even in self-catered accommodation was always maintained, and Brennan was used to making purchases online as his internet purchases of cannabis confirm.

5.69 There is no evidence that Brennan's ethnicity or culture impacted on Police interactions with him.

Term of Reference 8: *Although it is reported that the family carried out some clearing within Sofia's home after her fall in 2019 to deal with what was described as hoarding, is there any learning around hoarding and fire risks which are particularly relevant given the homicide occurred via arson? Had the clearing and decluttering carried out been maintained to ensure Sofia's continuing safety?*

5.70 Sofia's GP records are unclear if the decluttering carried out by her family had been maintained to ensure Sofia's continued safety. It is apparent that Sofia's son moved into her home as carer after this event. In June 2019 Sofia's daughter expressed concern to the GP that Sofia was neglecting herself and her GP offered to refer to Adult Social Care, but her daughter did not wish for this at the time. There were no further incidents of falls reported to the GP and no further issues of hoarding raised by Sofia, her family or the professionals visiting Sofia at home. The Norfolk Safeguarding Adult Board website has a Hoarding Strategy (2019)[56] plus an explanatory video. It highlights hoarding and self-neglect can be a safeguarding issue indicating a person can no longer manage self-care. Hoarding is a complex issue and whilst recognising people have the right to live as they wish, it can be a risk to the person and others for example increasing trip hazards and fire risks.

5.71 The Community Health & Care IMR confirms there was no evidence of hoarding or clutter when their clinician visited, their visits ended on 23 April 2019. Nor were there visible environmental concerns regarding this raised by the phlebotomist's visit in November 2019.

5.72 On 29 June 2020 Brennan reported to the Early Intervention Team that he was finding the 'state of the house' (clutter) difficult to deal with and it was impacting his mental state, he reported lots of boxes around. At a meeting with his consultant and case manager on 1 July to review his medication also attended by his father, Brennan repeated his complaint about the clutter. His father confirmed that he had removed some of the items from Brennan's room.

5.73 The Fire Service report no previous knowledge of Sofia's property and they had not had occasion to enter the property to assess any fire risk such as that associated with hoarding. The Fire Investigation found no evidence that any clutter or hoarding contributed to the fire development or outcome of the incident. Thus, it would appear that the earlier clearing of Sofia's home had largely been maintained.

[56] SELF-NEGLECT AND HOARDING STRATEGY AND GUIDANCE DOCUMENT (norfolksafeguardingadultsboard.info)

5.74 From the Police body worn camera video from the visit in December 2020 the rooms seen appeared relatively clean and tidy in the areas visited, however the upstairs walkways were very narrow due to bookcases placed on the landings. This could have hindered easy escape from the first floor in an emergency. The living room appeared to have paperwork on every surface and was untidy but did not appear cluttered; the interior seen did not suggest "hoarding".

Term of Reference 9: *All Individual Management Reviews (IMRs) to include analysis of whether questions asked in interviews or assessments were sufficiently probing and demonstrated professional curiosity to identify domestic abuse, or coercive and/or controlling behaviour towards the victim. This includes situations where interactions with parties reached the definition of domestic abuse*.

5.75 Direct questions were not asked of Sofia following the safeguarding referral outlining various issues alleged to be taking place in her home; some of the matters raised come under the definition of domestic abuse. Instead, Sofia's son who made the referral was asked to speak to his mother to seek her views. This has been reflected upon by the safeguarding adult practice consultant who supervised the assistant practitioner involved in establishing the facts of the matter. The practice consultant now believes it would have been preferable if the assistant practitioner had spoken to Sofia herself on the telephone at a time arranged to speak to her on her own. It is most welcome that this reflection has taken place and the importance of speaking to the person for whom concerns have been raised has been appreciated. Better still would be to see the person face to face on their own as advised by the Norfolk Safeguarding Adults Board[57] to assess their physical condition, home surroundings, and assess whether their views are freely given. It must be noted however, that with a camera in place covering the room, it would have been impossible to have a confidential conversation with Sofia, and as referenced previously there are unfortunately resource constraints to do this in every case due to the volume of referrals. According to school records, Brennan was thought to have stayed with Sofia briefly in June 2019 when he left school before going to Thailand on holiday, however had he been in the house when Sofia's younger son spoke to her his presence could also have impacted on her ability to speak freely had he been there.

5.76 Sofia's eldest son has confirmed to the Review chair that he would have welcomed an independent person interviewing Sofia in person as he would have been 100% confident that Sofia would have categorically refuted all the allegations, and she would have reaffirmed her wish to be cared for by him. In his opinion all the allegations of coercive control need to be clearly labelled as hearsay as there is no substantiating evidence.

5.77 The fact it was reported that Sofia was content with her care by her eldest son, had mental capacity, and did not want Adult Social Care involved meant the criteria for moving to a Section 42 enquiry was not met. The service's IMR explains there was no legitimate way to take the matter further without Sofia's consent, therefore there was no evidence to show that she was experiencing coercive control. Adult Services are faced with a challenge in terms of their ability to assess a person deemed to have mental capacity, but where there are allegations that they may be experiencing coercive control and therefore potentially be unable or fearful of expressing their real feelings and wishes as a consequence. The Care Act in tandem with the Mental Capacity Act functions within the ethos of proportionality and least restrictive practice, which is also informed by Article 8 of the European Convention on Human Rights; the right to respect for private and family life. It is debatable that this limits the discretion of services to enquire further where a person has capacity.

5.78 An option open to services if a person has capacity but cannot take decisions freely due to coercion, undue influence, or constraint, is an application under the Court's Inherent

[57] Domestic-abuse-older-adults.pdf (norfolksafeguardingadultsboard.info) See page 2

Jurisdiction[58]. However, this requires significant enquires, time, and evidence to put before the court. Such an application would not have been appropriate at the time of the referral concerning Sofia. The impact of legislation on accessing those who have capacity, but who may be subject to coercive control or affected by gaslighting or Stockholm Syndrome[59] would benefit from review now that the Care Act has been in operation since its enactment in 2015. It must be noted that the Inherent Jurisdiction route is rather draconian, resource intensive, and suitable for only the most intractable cases. It is rightly a last resort. Perhaps a middle way is required which enables confidential background information to be sought from third parties prior to contacting an alleged victim to better establish a picture of the person and the next steps to take. After all, Article 2[60], the right to life, should arguably override Article 8.

5.79 The recently published government research 'Safe Care at Home' (2023[61]) has identified a need for improvement in the interaction between the Mental Capacity Act 2005 and the Care Act 2014, citing as an example "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 publication also highlights variations in practitioners understanding of mental capacity. The fact that Sofia was not spoken to by a professional to assess her mental capacity was a flawed decision, and in the spirit of openness and reflection this has been recognised by the service during the Review. To support practitioners practice in dealing with the demands place on the service by the significant number of safeguarding referrals received, it would be helpful if the restrictions placed on them to investigate safeguarding concerns when a person is deemed to have capacity under the Mental Capacity Act was reviewed.

[58] The courts continue to develop and explore the extent and application of inherent jurisdiction, which is protective in relation to adults in vulnerable circumstances, and they will endeavour always to avoid undermining the principles in Section 1 of the MCA that an adult can take unwise decisions without this necessarily indicating a lack of capacity. Gaining access to an adult suspected to be at risk of neglect or abuse | SCIE

[59] Although Stockholm Syndrome is not listed as a formal mental health diagnosis, people who experience this syndrome appear to have common symptoms, including: 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 the 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. Stockholm Syndrome in Relationships: Impact On Mental Health (simplypsychology.org)

[60] Article 2 of the Human Rights Act 1998 - Means that nobody, including the Government, can try to end your life. It also means the Government should take appropriate measures to safeguard life by making laws to protect you and, in some circumstances, by taking steps to protect you if your life is at risk. Public authorities should also consider your right to life when making decisions that might put you in danger or that affect your life expectancy.

[61] Safe Care at Home, June 2023, HM Government. Safe_Care_at_Home_Review_.pdf (publishing.service.gov.uk)

5.80 The purpose of this Review is to primarily examine services' involvement with Sofia the victim, and Brennan the perpetrator of the crime which caused her death. Reviews are also intended to identify learning. The safeguarding referral did not relate to Brennan and there is no direct evidence that he was in Sofia's home at the time. The hypothetical nature of the discussion in the above paragraphs are intended to increase learning about domestic abuse more generally, and to highlight the challenges in the operation of the Care Act and Mental Capacity Act where coercive control might be a factor and the limitations placed on practice by these Acts. The DHR representative for Adult Social Care was unable to concur with the content of these paragraphs being of the view that too much weight was given to this subject area in light of the lack of evidence to support an allegation of coercive control. After going through a number of iterations and lengthy Panel discussions on this matter a consensus was achieved. In recognition of the issues identified within national legislation which are outside the control of this Review a national recommendation has been made below.

Recommendation:
That the Department of Health & Social Care, Home Office and in collaboration with the Domestic Abuse Commissioner for England & Wales commission urgent research 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. The results of the research should be used to inform the review being undertaken by DHSC to strengthen and clarify the Care Act 2014 guidance.

5.81 The Community Health & Care IMR found no documented concerns relating to domestic abuse or coercive or controlling behaviour and at the time of their involvement in 2019 no mention of Brennan is recorded. The community assistant practitioner identified that the voices of Sofia's son and daughter were prominent when they were present at visits, however the staff member was able to recognise this and gave Sofia opportunities to express her wishes so that her voice could be clearly heard. The clinician documented that the son and daughter were well meaning and there was no suggestion of any safeguarding concerns. As can sometimes be the case, family tensions and disagreements on the most appropriate actions to take for a loved one can take place. From the records described in the Chronology it is apparent that the assistant practitioner noted the feelings and wishes of Sofia herself at that time.

5.82 Whilst there were no documented concerns about domestic abuse or coercive control, the Community Health & Care IMR reflected that there appeared to be a lack of professional curiosity from the Continence Service when there were three cancellations of clinic appointments for Sofia by her eldest son on 7 October, 31 October, and 19 December 2019. These cancellations were followed by non-attendance by Sofia at an appointment arranged on 27 February 2020 (pre-Covid restrictions). There was no professional curiosity to follow this up and check why Sofia did not attend. Cancelling and missing a row of appointments should have been followed up with Sofia herself. Such missed appointments may in some cases indicate a person being isolated, neglected, or controlled and should therefore be followed up with the patient themself.

5.83 Brennan was noted in records by different mental health practitioners to be hard to communicate with, and at times he was monosyllabic. This meant probing open questions would often achieve limited response. Brennan himself was recorded as saying he was normally quiet. Nevertheless, there are points when further clarification was important to establish the context or meaning of what he was saying. Notable among these was when he was recorded as having 'concerns' about his grandmother. Understanding the context of those 'concerns' was relevant to understanding his relationship with Sofia and to assessing risk.

5.84 Brennan's father was a key source of important information, both in terms of Brennan's background history, and the home situation. However, from the records there are occasions when further probing and professional curiosity was required to understand the full picture. For example, on 31 May 2020 the information recorded from Brennan's father included that Brennan had a strained relationship with Sofia and he had a phobia about her, but the cause of the 'strained relationship' and what was meant by 'phobia about her' and how this manifested itself appears not to have been clarified, or it has not been recorded. Brennan's father stated to the chair that he described detail about Brennan and his relationship with Sofia many times, but he reports that it seems information was only recorded by practitioners they thought important. He reported that Brennan thought his grandmother did not like him, but the reality was the opposite and Sofia was always kind to him and went out of her way to please him.

5.85 The call handler who took the 999 call from Brennan's father appropriately probed to ascertain what his concerns were; from his voice he appeared to be agitated, anxious and under duress, and his description of events reflected this, resulting in the call handler repeatedly asking clarifying questions whilst simultaneously deploying officers to attend and assuring him that officers were on their way.

5.86 The interactions between officers attending in December 2020 and Brennan and his father were reviewed by a police inspector who, prior to joining the force, had 20 years' experience as a mental health nurse and had been instrumental in setting up the Mental Health Advice Team[62] in the Contact and Control Room. The inspector's observations included in the IMR for the Panel were:

'Brennan's father showed the obvious fear that he had of his son and concerns around his behaviour; he seemed frantic, in a concerned state and was visibly distressed and made it clear he genuinely feared his son would harm him. He appeared anxious and was constantly moving about the room rather than standing still to interact with Officer F.

The interaction between Officer B and Brennan was brief with closed statements. [The inspector] stated that when dealing with people who are suffering from mental ill health it is good practice to ask how they are feeling or if they recognise anything is wrong. This demonstrates insight into their mental health and provides a good indication as to how they are thinking. Officer B did not explore with Brennan how he was feeling to ascertain if he thought that there was anything wrong with him. Brennan gave short answers to questions/statements put to him but did not give a clear explanation about the incident and appeared distracted and distant – he did not really explain anything about what had caused his father to call the police'.

There was no discussion between Officer B and Officer F about what the parties said; that officers appeared to believe it was just an argument over a phone rather than a sign of poor mental health. Officers could have questioned Brennan further about what had caused the police to be called that night and discussed with him how he was feeling and thinking given that they were aware he had mental health problems. Brennan would have had to agree to any referral to the Crisis Team.

[62] The Mental Health Advice team consists of 6 nurses who provide guidance and advice to staff and officers across the organisation where there is evidence of mental ill-health. Guidance and advice can be varied and can be in respect of spontaneous incidents and historical information to assist operational officers. Their working hours end at 22:00hrs which means they were not available to assist officer attending the incident in December 2020. Outside these hours officers have the option of contacting the Mental Health Crisis Team via their 24/7 telephone support service for individuals currently open to Norfolk & Suffolk Foundation Trust and who find themselves in mental health crisis.

5.87 The Review author, having also viewed the video footage with two members of the Panel, would concur with the inspector's views. Crucially the absence of open questions to Brennan meant there was no imperative for him to explain events or express how he was feeling, and this enable him to avoid answering questions in any meaningful way to illicit his state of mind and what had taken place. Brennan was not asked to sit up in bed to engage more fully with officers so that he could be heard more clearly; he remained lying down with his hooded head just visible above the duvet. Asking him to sit up and speak to officers could have invoked a more serious tone to the interview which at times felt like a one-way conversation, and Brennan's body language would have been visible to inform officer's assessment of him. Given the 999 call had been made by his father who had expressed his fears about Brennan's behaviour towards him there was a lack of challenge and probing by officers interviewing him.

5.88 As previously stated, officers did not interact with Sofia; they accepted Brennan's father's explanation that she was in bed and would not have heard anything because she was deaf. Officers had noted her closed bedroom door and appear to accept this meant Sofia was in bed asleep. However, her door could have been closed as a means of protecting herself from what was taking place between her son and grandson or closed by someone else, but it is not possible to confirm this. There was a lack of curiosity as to whether Sofia had heard or seen what happened, and if so, a missed opportunity to learn more, hear her views, and to give her reassurance by explaining their presence.

5.89 Lack of professional curiosity is a theme found in a variety of Reviews. The importance of professional curiosity is included in Safeguarding training slides delivered by St Thomas Training commissioned training providers in the county in which it is defined as:

- Professional curiosity is a combination of looking, listening, asking direct questions, checking out and reflecting on information received.
- It means not taking a single source of information and accepting it at face value.
- It means testing out your professional assumptions about individuals we encounter.
- It means triangulating information from different sources to gain a better understanding of the individual which, in turn, helps to make predictions about what is likely to happen in the future.
- It means seeing past the obvious.

5.90 All the above points are relevant for the agencies contributing to this Review, especially those whose duties include risk assessments.

Recommendation:
All services should reinforce within their policies and procedures, and in staff supervision, the importance of professional curiosity and what this entails in practice, and
a. Practitioners and their managers should be reminded of the steps to take as described in the Safeguarding training with the aim the of achieving the fullest, corroborated information for assessments as possible.
b. Anyone expressing concern for another person during an assessment or interview should be asked for examples and to describe those concerns, and this must be recorded in detail.

Term of Reference 10: *Were there any resource issues, including staff absence or shortages, which affected agencies' ability to provide services in line with procedures and best practice? Include caseloads, management support of staff, supervision, and any impact of changes due to restructures or to service contracts.*

5.91 The Mental Health Trust IMR and the Independent Mental Health Homicide Review identified at the time Brennan was first Sectioned in May 2020 there were no NHS psychiatric beds available in the Trust's area. As a result, he was referred to a `within-area' private provider who had a contract with the NHS, an arrangement confirmed as completely normal in such circumstances. The Review observe that beds (as elsewhere in

the NHS) are in short supply in mental health services and waiting lists can be challenging. In this case, the arrangements to find Brennan a bed were judged to have been managed appropriately.

5.92 The Mental Health Homicide Review concluded that staff shortages, staff training, and arrangements for supervision of staff were not problematic at the time of involvement with Brennan, nor was there ongoing restructuring.

5.93 All other contributing agencies confirm no resource issues were identified during the period under review, other than changes brought about by Covid-19 restrictions, and the stresses caused by trying to maintain services in line with best practice during what was a potentially fatal virus.

5.94 One exception concerns the ability to release all front line team members for special training workshops as cover is always required for this to take place. The safeguarding adults practice consultant for example could not attend a one-off workshop on domestic abuse and coercive control but was updated by a team member later. It was noted that domestic abuse was not a mandatory training course at the time under review, but Adult Social Care confirm that this is now the case. This enables practitioners to attend the course on a phased basis ensuring staff cover can be maintained for the service.

5.95 The Adult Social Care IMR did not identify resourcing as an issue but it was noted by the Review Panel that Adult Social Care reported a significant number of safeguarding referrals in the county - over 400 per month. A national recognition of staff resource shortfalls in Adult Social Care has been highlighted by the Association of Directors of Adult Social Services (ADASS)[63] which identified a rising complexity of needs for care, and directors doubts that they would be able to meet their statutory duties. Norfolk has a higher proportion of older residents compared to other counties as cited in the Equality section of this report. In addition, the county's Director of Adult Services and the local media have highlighted the high cost of housing, level of second homes, plus lack of sufficient affordable housing in the county which causes additional difficulties in recruiting and retaining staff.[64] It is therefore legitimate to ask: is the county sufficiently resourced to undertake the required level of investigations effectively and safely with this volume of referrals? These higher strategic level resource issues could have an adverse impact on safeguarding operations.

Term of Reference 11: *Were the family made aware of the availability of a Carer's Assessment and relevant benefits such as Attendance Allowance to contribute to the support of caring for Sofia?*

5.96 Sofia's GP notes had no record of a carer's assessment being discussed. Her eldest son attended an appointment with her to the practice nurse, but it is not clear from her records whether he accompanied her into a GP appointment in June 2019 when she attended due to swollen ankles. Such appointments would be an opportunity to give information about carer assessments.

5.97 Records note that a discussion about Attendance Allowance took place between an assistant practitioner from the Social Care Community Engagement team and Sofia's daughter during a preventative assessment on 1 March 2019. It was noted that the application form had been completed, and a decision awaited from the Department of Work and Pensions. It is not recorded whether the Allowance process was completed and payments made, but the chair was informed by Sofia's daughter that she completed this process for Sofia following advice from Sofia's co-LPA.

[63] Social care waiting lists up 37% in 6 months, finds ADASS - Community Care
[64] North Norfolk News 24 February 2023

5.98 The Adult Social Care IMR found a carers assessment was not offered to any member of the family but identified that it would have been appropriate for information to have been given. The Social Care Community Engagement service manager advised that during all contacts, assistant practitioners should be identifying carers and directing them to Carers Matter Norfolk who are commissioned to give advice and carry out carers assessments. The service manager reported that during 2021 the service carried out awareness raising about carers and there have been improvements in staff recognising their responsibilities to identify and support carers.

5.99 The IMR author discussed with the safeguarding adults practice consultant whether it would have been appropriate to offer Sofia's eldest son a carers assessment at the time of the safeguarding referral. However. it was felt inappropriate to contact him at this point to offer the assessment as the referral from his brother raising a safeguarding concern was about him, but on reflection, there was an opportunity to advise the referring son that if he felt his brother was struggling to care for their mother, his brother could be invited to call Adult Social Care to request a carers assessment. This was not done. A recommendation relating to carers assessments being offered and taking place was previously made in a Norfolk DHR completed in October 2020, and Adult Social Care had carried out work to raise awareness of carer's assessments among practitioners in both February and March 2020 in addition to the work done in 2021 reported above. A previous recommendation was also made in the 2020 DHR that 'Promotion of the guidance (on the assessments) should be undertaken on a 6 monthly basis to acknowledge changes in staff', therefore a further recommendation will not be made. However, the degree to which carer's assessments are embedded in routine practice is again raised in this case, therefore a recommendation will be made to undertake regular audits of carer assessments being offered and taken up to ensure improvements take place and are maintained.

Recommendation:
To ensure improvements in offering carer's assessments is maintained, an annual audit of recording of carer assessments offered, and carer assessments taken up should be undertaken.

Term of Reference 12: *Given Sofia's diagnosis of cognitive impairment in 2017, and 2018 follow up assessment by a consultant psychiatrist from the Memory Assessment and Treatment Services regarding continuing memory problems, was her registered Lasting Power of Attorney (LPA) involved in all assessments and decisions, and if not, why not? GP IMR to include whether a follow up assessment or assessments of Sofia's cognitive impairment took place as planned after the 2018 assessment and the results of any further assessments.*

5.100 The role of a Lasting Power of Attorney (LPA) is to make best decisions on behalf of someone should they lack mental capacity as defined by the Mental Capacity Act 2005. Even if a person has appointed an LPA if the person has mental capacity, they are deemed to be able to make decisions for themselves. For example, if they can[65]:

- understand the information they need - for example, what the consequences will be and remember the information for long enough to make the decision;
- weigh up the options and make a choice;
- communicate their decision in any way - for example, by blinking or squeezing a hand; then a person is deemed capable and will not require their LPA to make a decision on their behalf.

5.101 Adult Social Care confirm that the service was not made aware at any point that Sofia had an LPA. The Panel learnt the service does not enquire about the existence of LPA's.

[65] Make decisions on behalf of someone: Checking mental capacity - GOV.UK (www.gov.uk)

During their contact in June/July 2019 following the safeguarding concern referral, they consulted with Sofia's youngest son who spoke on the telephone to Sofia at the request of the assistant practitioner about the referral. It was recorded that Sofia had mental capacity; therefore, no LPA would be required to make a decision on her behalf. Sofia's daughter, who was one of Sofia's LPAs, was involved with Reablement Services in March 2019 when she was caring for Sofia as she had requested and organised the support service for Sofia. This would not have required LPA duties as there was no indication or concerns within the Reablement Services that Sofia lacked capacity.

5.102 Sofia's GP IMR confirms her assessment by the consultant psychiatrist on 26.06.2017 and 27.02.2018 regarding her memory. Her condition had not varied between these two reviews. Information about any early signs of dementia were explained to Sofia and her daughter who held Lasting Power of Attorney for health and welfare. Sofia was provided with information regarding a pendant alarm and discharged from the memory clinic at this stage. No further concerns regarding progression of symptoms were raised by either of the professionals caring for Sofia, or her family after this, therefore there was no indication the GP surgery needed to refer again to the memory assessment clinic. The GP confirmed that Sofia's daughter who was one of her LPAs for health and welfare accompanied Sofia at the consultations with the consultant psychiatrist.

Term of Reference 13: *Were the actions or information sharing by those involved with either Sofia or Brennan 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.*

5.103 Adult Social Care's IMR reported that information sharing was not limited by GDPR duties or a concern about sharing information with regard to their involvement. However, the reason given for not contacting Sofia's GP for information to confirm her mental capacity or vulnerabilities was that Sofia's consent was required before they could do this. Thus, GDPR does appear to affect this part of their procedures. Norfolk Community Health & Care NHS Trust also reported no occasion arose which required information sharing during their support of Sofia after her fall. The Manchester Medical Practice at which Brennan was registered had no contact with him, hence no need arose to share information.

5.104 The Mental Health Trust undertook a normal routine sharing of information via letter to Brennan's new GP in Manchester as it is a branch of the NHS but was constrained by patient confidentiality in sharing information outside this sphere without Brennan's consent, which he did not give. This prevented information sharing in respect of onward referral to services in Manchester, including the university. He also refused consent to share information with his father, although his father was present at some appointments with the Early Intervention Team, and he took part in meetings or conversations with hospital staff when Brennan was under Section and deemed not to have capacity. Information sharing in the Health context is governed by patient confidentiality in addition to GDPR.

5.105 The Mental Health Trust reviewed their actions with the Caldicott Guardian[66] who confirmed that whilst the NHS services could share information without a service users consent, there would have to be a compelling reason to do so. The Caldicott Guardian did not identify any compelling reason or need in this case. If Brennan had come to the attention of another area's services, they would have been able to contact the Trust for information or advice about him, however, this did not arise.

[66] A Caldicott Guardian is a senior person within a health or social care organisation who makes sure that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. https://www.ukcgc.uk/

5.106 Police action was not affected by GDPR. Their IMR explained any duties under GDPR would be considered but are unlikely to inhibit information sharing within the Multi-Agency Safeguarding Hub (MASH).

5.107 Under GDPR a person's consent must be given to share their personal data. Where it is shared there has to be a 'legitimate interest' which must be justifiable. In the personal sphere for example this could be where a person is asked by their employer to provide an emergency contact in case of a serious accident at work but it will only be used for that purpose. The impact of holding those personal details is very low as they will only be accessed in an actual serious emergency[67]. No agency in contact with Brennan following his discharge from hospital, identified such an emergency i.e., due to violence or in the prevention of a serious crime for example.

5.108 This matter relating to the university is discussed in detail in Term of Reference 36.

Adult Social Care:

Term of Reference 14: *To analyse the safeguarding process and decision making following the receipt by Adult Social Care of the letter raising a family safeguarding concern on 18 June 2019.*

a) Were existing safeguarding procedures fully followed?

5.109 The IMR addressed this section under the criteria set out in Section 42(1) of the Care Act which states that the safeguarding duties apply to an adult who:

- *has needs for care and support (whether or not the local authority is meeting any of those needs)*

5.110 Sofia was reported to need support to manage her personal care and was assisted to maintain her activities of daily living by her eldest son, and in his absence overseas professional carers were employed to visit her daily, therefore it is demonstrable that Sofia did have care and support needs.

- *is experiencing, or at risk of, abuse or neglect.*

5.111 Enquiries carried out in June/July 2019 by Adult Social Care as set out in the chronology (paragraphs 3.38–3.40) involved asking Sofia's younger son to seek her views and wishes. As he lives a considerable distance from his mother, Sofia's son confirmed to the chair he did this via a telephone call; Sofia was not therefore seen in person. The information fed back and recorded led the safeguarding adults practice consultant to believe that Sofia was neither experiencing nor at risk of abuse or neglect. However, as Sofia's youngest son was unable to see her in person it is arguable that this was inadequate to fully assess the situation in terms of determining abuse or neglect. Sofia was not seen to assess how she looked, her surroundings, and importantly, whether she was on her own at the time of the call to enable her to speak freely. If someone else was present this could have formed a barrier to Sofia feeling able to openly express her views. The assessment limitations placed on practice by the legislative process have been discussed earlier at paragraph 5.71, however, it is important to reinforce learning regarding the potential barriers to effective assessments in this and any similar future cases.

5.112 When communicating with Sofia's youngest son, he reported to the chair that his mother did seem content, but he suspected she was simply happy that her eldest son was living with her; and it was the company of her eldest son not the care that she appreciated. Sofia's

[67] Information Commissioners Office: Does an organisation need my consent? | ICO

younger son recalled that when the assistant practitioner from Adult Social Services explained that in the absence of any complaint from his mother, they would not make a home visit to see for themselves that she was alright, her son told the chair he was completely flummoxed. He had explained to the assistant practitioner that his mother would never make a complaint about her first born son, but he was told this was their process. As research cited earlier (paragraph 1.37) highlights, many experiencing domestic abuse do not wish to see their family member in trouble, and this too can form a barrier to reporting abuse or neglect. Also, as her younger son observed, his mother enjoyed the company of her eldest son and continuation of this might be impacted by a complaint.

5.113 Sofia's younger son explained she was not at all happy about the camera which had been discovered by her granddaughter. She had been told by her eldest son it was a burglar alarm. Her younger son explained he had this conversation multiple times with his mother as by then her short-term memory was very poor. Sofia's youngest son reflected to the chair that he noticed on many occasions as his mother picked up the phone, he could hear someone bounding down the stairs, and after an initial greeting his mother would say that his elder brother was there and would he like to speak to him? He would reply 'No, he wanted to speak to her not his brother'. He said this routine happened at almost every call. The camera installed by Sofia's eldest son was described as in the living room pointing in the direction of the phone. After learning of the camera Sofia's youngest son told the chair he became much more guarded in the conversations he had with his mother. Sofia's eldest son reported to the chair that he had installed the camera to monitor the content of 'phishing' or scam calls, and to check on his mother's safety when he was away; he said Sofia was happy with the camera and had explained this to everyone including her solicitors. He also explained the reason he appeared to rush downstairs when the phone rang (see footnote below[68])

- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.*

5.114 The IMR found this criterion not to be applicable as no abuse or neglect was identified. However, there is a strong case to argue that as a frail 88-year-old woman who did have care and support needs Sofia would have been unable to protect herself from the risk of abuse or neglect. As we know she was left on her own and was unable to escape to protect herself from the fire which was set by her grandson.

5.115 For the sake of clarity further information was sought to aid the Panel's understanding regarding the decision-making process, guidance given to the assistant practitioner, and whether the supervisor had read the letter setting out in detail the safeguarding concerns before giving advice. The safeguarding adults practice consultant reported to the IMR author that if the letter was recorded on the LAS database system in the contact record, they would have read it before speaking with the assistant practitioner. The safeguarding adults practice consultant confirmed they always tried to read the information on the LAS database before speaking with the assistant practitioner or a social worker, as this allows time to process and consider the information before giving a view and guidance.

5.116 The safeguarding adults practice consultant reflected in hindsight they would have asked the assistant practitioner to speak directly to Sofia on the telephone to ask her to corroborate her younger son's account and asked the care agency to comment. However, as mentioned above, the belief was that it was extremely likely that Sofia had the capacity

[68] The house phone only rang for about 4-7 rings and then went to answering machine mode and he could not increase this ring time. Sofia would not normally be able to get up and answer the phone if she was in her armchair watching TV, and the only way that Sofia's eldest son could answer it in time was to literally run the stairs as he was normally studying upstairs.

to decide to continue with her eldest son as her carer. Her finances were managed by another son and her care needs were reported by the referring son as being met by paid carers on occasions. It appeared to Adult Social Care that family members were not prevented from visiting, but they had to call in advance before doing so. This was not questioned in assessing Sofia's situation. Sofia was aware and thought not to object to the camera in her house; she believed this was a protective factor as she had been vulnerable to phishing calls. Adult Social Care assessed there would have been no grounds to remove her from her eldest son's care.

5.117 As stated before, it is appreciated that on reflection the safeguarding adults practice consultant would have advised more proactive enquiries to be made, for example asking the care agency for comment, similarly it would have been helpful to include checks with Sofia's GP to confirm her capacity and any vulnerabilities she may have, but the Review Panel was informed that without Sofia's permission seeking information from her GP would not have been permissible without the referral reaching the Section 42 criteria. Contact details for family members had been given, but no contact was made to seek their views as concerned family members. In addition, the reason family members needed to phone beforehand to visit Sofia should have been a cause for disquiet, especially as it was previously the custom of her adult granddaughter to 'pop in' when she was in the area and this was always acceptable to Sofia, especially as Sofia had provided childcare for her granddaughter from an early age and she had her own house key. Prior to the change in living arrangements to care for Sofia, her daughter who lives a short distance away had also visited Sofia regularly. To arrange to visit one's own closest relative when no previous restrictions have been in place removes spontaneity and the ability to just 'call in'. Whilst some families may prefer warning of a family visit for a variety of reasons, importantly this had not previously been the case for Sofia. Such changes in longstanding visiting arrangements in conjunction with other areas of concern should have raised questions and been probed further. Adult Social Care felt having to make an arrangement to visit was not a safeguarding issue, but through the lens of domestic abuse, changes restricting visitors or isolating someone from their family and friends is a common technique in cases of coercive control associated with other forms of domestic abuse; this required further probing to establish whether there was evidence of controlled access to Sofia which had not previously been the case. Brennan's father explained to the chair that he asked Sofia's granddaughter to make appointments to visit as she had entered the house one day when he was coming out of the bathroom, and he was uncomfortable with this. The chair was informed by a family member that when Sofia was told her daughter and granddaughter felt they needed permission to visit and no longer felt comfortable about this, Sofia was very upset and stated clearly that she did indeed want them to visit her. Sofia's eldest son insists he did not prevent or forbid his siblings from visiting Sofia. However, this was not the perception of Sofia's daughter and granddaughter who informed the chair in the strongest possible terms that they felt prevented from visiting.

5.118 Adult Social Care received no contacts or referrals concerning Brennan. At the time of the safeguarding concern no members of the family, apart from his father, would have known whether he stayed in Sofia's home. Brennan left school on Thursday 13 June 2019 and his leaving address was recorded by the school as Sofia's home. His father confirms that Brennan did not stay at Sofia's home on leaving school, he did not want to, he went to Thailand for the summer holiday that weekend. Therefore, Brennan would not have been with Sofia when Sofia's younger son spoke to her on the phone in July.

b) Were other agencies and service providers contacted to share information regarding background history about the victim and perpetrator's situation, vulnerabilities affecting the victim and impact on her care needs, any previous concerns, and their views on the safeguarding concerns raised.

c) What direct assessment did Adult Social Care staff themselves undertake to inform decision making?

d) Was the decision not to take the family's concerns further made with full and corroborated independent information?

Regarding Sofia:

5.119 There were no checks to corroborate any of the concerns raised in the referral letter, no information sharing with other agencies or service providers, nor direct assessments undertaken involving Sofia herself. There is no evidence that Social Care records were checked to see if Sofia was already known; this would have revealed Sofia's support from First Response, her frailty following a fall, and need for carers at that time.

5.120 We do not know categorically if Brennan was in Sofia's home during the time the referral was made as she was not spoken to about her household and how she felt, but school information showed his leaving address recorded as Sofia's home in June 2019. We know that Sofia was so distressed by his behaviour at the beginning of 2019 that she left her home seeking help from her daughter. Had Sofia been spoken with sensitively in person about any concerns she might have, any disquiet about Brennan's presence might have emerged. There appears to have been no recognition or understanding that if Sofia was experiencing coercive control, then she would find it difficult to express her views, especially to her youngest son who had been asked to speak to her, and she would possibly not even recognise such behaviours affecting herself. Gaslighting[69] is well known to affect how a person thinks and believes what is happening to or around them. Sofia may have had mental capacity, but she did have some short-term memory problems, this could also possibly contribute to the accuracy of her perception of what was taking place.

5.121 For Sofia it was vitally important to her that she remained living in her own much loved home. This was paramount to her and she was adamant about this. Due to her increasing frailty having her eldest son living with her enabled her to achieve this. It is likely that Sofia was aware of this and therefore would not do anything to affect this arrangement. This created an additional power imbalance between cared for and carer, along with the physical restrictions and dependency imposed on her by increasing age and frailty. It is also possible that in her advanced years Sofia wanted peace and equanimity in her life and did not want any reason for disharmony in her family which Social Services involvement might bring. Indeed, Sofia's daughter confirmed to the chair that her mother was averse to disharmony, confrontation, and arguments, and for this reason the family stepped back to allow her peace at home in her twilight years whilst trying to protect her to enable her to live as she chose. In light of this it must have been difficult for the younger siblings to make the decision to submit a safeguarding referral to Adult Social Care.

5.122 It is of note that the Norfolk County Council practitioners domestic abuse training contains a slide entitled 'Inter-agency work – we need to avoid the silos'. Inter-agency working did not take place in this case when assessing the safeguarding referral concerning Sofia, had it done so the assessment process would have benefited from the fact that Sofia's GP had relevant information about concerns raised by her daughter and Sofia's frailty and memory problems. The effective operation of the coordinated response to domestic abuse crucially relies on information sharing and the avoidance of silo working. The MASH system is designed to prevent this, but multi-agency coordination was not evident following the receipt of the safeguarding concern. The referral was received and handled by Adult

[69] Gaslighting is an insidious form of manipulation and psychological control. Victims of gaslighting are deliberately and systematically fed false information that leads them to question what they know to be true, often about themselves. They may end up doubting their memory, their perception, and even their sanity. Over time, a gaslighter's manipulations can grow more complex and potent, making it increasingly difficult for the victim to see the truth. Gaslighting | Psychology Today

Services 'Front Door' call centre, not the MASH. However, the assistant practitioner did consult a safeguarding adult practice consultant based in the MASH, but this did not result in any extra checks. Brennan's assaults and when he was Sectioned would not have appeared as this was in May 2020 the following year.

5.123 The Adult Social Care IMR noted that no further contact raising concerns was received from Sofia's family prior to her homicide 18 months after the safeguarding referral. However, this is explained by the fact that Sofia's youngest son had been told that unless his mother herself made a complaint Social Care could not act or make a home visit. He reported to the chair that this, plus the fact that the rest of the family knew Sofia loved her eldest son and would never make such a complaint, meant they felt thwarted by a policy which they believe is not fit for purpose to protect vulnerable adults and which puts others at risk.

Regarding Brennan:

5.124 Prior to Brennan's first admission to hospital for treatment under Section 2, the approved mental health professional (AMHP)[70] liaised with the Crisis Team and gained background information from his father to inform their AMHP Report, thus information was shared about the incident leading up to his admission and the risks he posed to Sofia and his father by his actions.

5.125 The Adult Social Care IMR found it was not clear whether this report was acted upon when Brennan was discharged from hospital; Adult Social Care was not part of the discharge process. Only those receiving treatment under Section 3 are entitled to aftercare from Social Care under Section 117 of the Mental Health Act, and the Mental Health Trust would make a referral as part of discharge planning if care and support was felt necessary. However, there is a system whereby reports are uploaded and shared with the Mental Health Trust in a set timescale; this is monitored closely by the Trust. The IMR author discussed the process around the sharing of reports with the Mental Health Trust with the head of service for the Adult Mental Health Team within Social Care. There was a lack of clarity from their perspective concerning the location and ease of retrieval of the AMHP report on the Trust's system. Anecdotally, the IMR suggests the information can be difficult to find on the system.

5.126 In this case such uncertainty about the location of the AMHP report was not justified. During the independent NHS England Mental Health Homicide Review team's work they could see both the handwritten report written by two doctors and the approved mental health professional, plus the typed version. Both were present on the system and were definitely shared with Southern Hill Hospital; it was visible to the team on the electronic records.

5.127 Reflecting on how to enhance the transfer of safeguarding concerns to admitting hospitals and thus information being available to inform discharge; an agenda item was added to the Approved Mental Health Professionals Forum to share the learning from the IMR and including the need to verbally hand over safeguarding concerns for others which will be relevant to consider on discharge. Approved mental health professionals will be made aware that they must hand over safeguarding concerns in person and record on the Adult Social Care LAS database that they have done so. This was early learning from the Review and the Forum at which learning was shared and the need to verbally handover concerns took place on 10 January 2023.

[70] Approved mental health professions (AMPH) are employed by Local Authorities as required by legislation. Their work includes mental health assessments and they work across and between Mental Health Trust and Social Services.

5.128 The Review Panel sought clarification regarding how this change arising from IMR learning would not be lost, for example in relation to new approved mental health professionals joining the service. Following consultation with the head of the local authority Adult Mental Health Team, the Panel was assured that the handover process change will be incorporated into training for new approved mental health professionals each year as a component of University of East Anglia training which is led by practice consultants from the Core Team. In addition, it is suggested to add safeguarding to the approved mental health professional supervision templates. The Adult Social Care IMR has made a recommendation concerning this issue.

5.129 The design of the Mental Health Act AMHP Report template has been considered by the Panel and the layout is not conducive to making the risk section readily visible. Risk to others in particular does not feature on the final page Outcome section. A suggestion was made at the third DHR Panel concerning how the template could be reformatted to sum up the important information on the last page of the report in a coloured text box to make it clearly visible, in which information could be contained to inform risk assessments. A recommendation was made on page 64 concerning the template design.

5.130 The Mental Health Trust's own inquiry also made a recommendation to enhance transfer of information which is shown below.

c) What risk assessment tool or checklist was undertaken?

5.131 As the information which was recorded to have been fed back to Adult Social Care by Sofia's youngest son was judged to indicate no abuse was taking place no risk assessment was undertaken. The details listed in the letter do not mention physical abuse, but there are aspects which are consistent with other domestic abuse or controlling behaviours. However, there was no consideration given to using the DASH[71] checklist to establish the behaviours which might apply and the level of risk.

5.132 The Approved Mental Health Professional Report contains a free text risk assessment section. There is no actuarial risk assessment tool or checklist to aid the practitioner in formulating their assessment. It is based on the professional judgement and the experience of the practitioner. The chair has been provided with a copy of the Mental Health Trust's Clinical Risk Assessment and Management document Version 09.2 (2021) which gives thorough and comprehensive guidance for clinical staff undertaking assessments.

e) Why did Adult Social Care not make a home visit to speak to Sofia on her own to inform their assessment? Why did Adult Social Care not discuss the situation with Sofia's LPA?

5.133 The services' IMR explained that the Care Act requires a proportionate approach to safeguarding (for adults). Information recorded as being provided by Sofia's son who made the safeguarding referral is stated to have led the practitioners to believe that she did not consider she was experiencing abuse or neglect at this time, and Sofia had capacity to make the decision to remain living with her eldest son as her carer. Sofia is recorded as saying she did not want Social Services involved. As reported in Term of Reference 14 in hindsight the Safeguarding Adults practice consultant would have asked the assistant practitioner to call Sofia directly to corroborate the information in the referral letter. A home visit would have been considered had her son expressed concerns about his mother's capacity or if she had concerns about her eldest son's behaviour as her carer.

[71] Domestic Abuse Stalking & Harassment checklist – an evidence based actuarial risk assessment tool to assist practitioners in judging the level of risk faced by a victim of domestic abuse. It supports practitioners' professional judgement.

5.134 Sofia's youngest son informed the chair he held the exact opposite view to that inferred in the paragraph above and would not have said what is attributed to him. He took issue with the care of his mother, but Sofia loved his elder brother and she liked having him there, but he (and she) were too embarrassed for him to provide any essential intimate care. This is why he and his other siblings were prepared to pay for carers. He is of the view that the reasons given for when a home visit would take place are an entirely false justification for the inaction of Adult Social Care despite what he describes as 'begging' that someone visit his mother. He is of the opinion "if this was their 'policy' then it is not safeguarding in any way shape or form – victims do not realise they are being controlled/coerced/abused". In his email to the chair Sofia's youngest son wrote 'Whatever happened to the third word in "Adult Social **Care"**?

5.135 The fact that Sofia was considered to have mental capacity based on the information recorded on the Adult Social Care records, meant no enquiry was made about whether Sofia had an LPA who would need to be consulted. It was known from the referral that one of Sofia's younger sons managed her financial matters, but no enquiry was made to establish whether she had an LPA for health and welfare for the record in case it was relevant. Recording a person's LPA is important information and services would be wise to record this (a recommendation is made as part of the Professional Curiosity recommendation). Sofia had entrusted one of her adult children as LPA and another as an alternative LPA and their names were among those on the referral to contact for further information, but they were not contacted for their views. From the information presented to the Review it seems clear that whilst Sofia did have short-term memory difficulties, she did not have a dementia type illness or lack mental capacity.

f) Was the decision not to take the family's concerns further made with full and corroborated independent information?

g) Are the current safeguarding policies and procedures fit for purpose to ensure the safety and wellbeing of similar vulnerable adults as Sofia?

5.136 The IMR for the service was of the view that the policies and procedures are fit for purpose. The limitations of decision making and lack of corroborated independent information has been discussed earlier, but to reiterate no corroboration of the information was sought from family or services sources.

h) Does Section 42 of the Care Act 2014 require review and amendment to increase the safety and wellbeing of vulnerable adults and to assist professionals in their work to achieve this?

5.137 The IMR states Section 42 of the Care Act, backed up by the statutory guidance and the ADASS/LGA frameworks (adopted by Norfolk), is clear about the criteria for raising a safeguarding concern and a Section 42 enquiry. While it is not felt that Section 42 needs to be amended, the IMR suggests consistency in reporting of safeguarding concerns nationally would be improved by bringing the ADASS/LGA framework into the statutory guidance. It is arguable however that national consistency of reporting of safeguarding concerns is not achievable due to the varying nature and types of abuse experienced within diverse communities across the country. Being too prescriptive could result in cases being missed, and as recommended earlier in this report (page 71) a review of the Care Act vis a vis the ability to make enquiries where coercive control may be a component requires examination.

Mental Health Services:

Term of Reference 15: *What risk assessments were undertaken by Mental Health Services during their contact with the alleged perpetrator and:*

a) What was the risk assessment outcome of the perpetrator's 'risk to others'?

5.138 The risk assessment model used by the Early Intervention Team and the hospital to which Brennan was admitted at the start of June 2020 is based on that published by the Royal College of Psychiatrists. Areas covered in the risk assessment included:

- Diagnosis
- Social & familial factors
- Social behaviour
- Substance misuse
- Conditions and mood
- Triggers for risk behaviour (i.e., substance misuse or alcohol) & potential mitigations
- Arrangements for a crisis

The Mental Health Trust's Clinical Risk Assessment and Management guidance[72] cites the Royal College of Psychiatrists guidance on risk formulations which states *"it should take into account that risk is dynamic and, where possible, specify factors likely to increase the risk of dangerousness or those likely to mitigate violence, as well as signs that indicate increasing risk." (p4)*. Service users under the Care Programme Approach, as Brennan was on discharge, are expected to have an update at each review and as needed where the service user's presentation changes.

5.139 On admission to Southern Hill hospital Brennan's was assessed as 'medium' risk due to the altercation with his father. At discharge from hospital and the Section 2 Brennan's risk was assessed as low following his treatment. Risk assessments contained arrangements in a crisis. The Mental Health Homicide Review team examined the notes and concluded that formal and informal risk assessments were appropriate at the time they were made.

5.140 The combined risk and assessment undertaken by the Early Intervention Team was dated 26 June 2020. The Trust's IMR judged this to be below the standard they would expect with the caveat that Brennan had not fully engaged or was known well by the team due to the short time period of their involvement with him. However, there appears to have been no reassessment of risk after Brennan admitted in July to recommencing using cannabis and drinking. Given this was against advice due to the consequences for his mental health, risk should have been reviewed and recorded. The IMR observed, that the notes were of a good standard and they showed the practitioner's good overall understanding of Brennan and the risks presented, although it should be noted that no home assessment took place prior to discharge. The IMR assessed any omissions in the paperwork would not have contributed adversely to the Service's handling of Brennan's treatment. However, an updated risk assessment on file is a valuable tool for another staff member picking up a case in the absence of the practitioner.

b) Did he express any specific threats or animosity towards individuals or family members? If so, what was done with this information?

5.141 Enquiries for the Review provided by the Mental Health IMR and the independent Mental Health Homicide Review for NHS England show Brennan's risk assessment was rated 'low' when he was discharged from hospital after treatment. Prior to this, in the early stages of his psychotic illness on his admission to the hospital, his risk to others had been assessed as 'medium' risk due to the altercation with his father.

5.142 The Mental Health Trust IMR notes risk was no longer a feature of Brennan's presentation on his discharge. However, it was noted that he had been verbally aggressive to his

[72] Norfolk & Suffolk NHS Foundation Trust, C82: Clinical Risk Assessment and Management. Version 09.2 (2021)

grandmother and a neighbour, and physically abusive to his father, possibly also to his mother historically, but this was uncorroborated.

5.143 The Mental Health Homicide Review found electronic notes are 'silent' with respect to Brennan's attitude to Sofia. One of the Early Intervention Team staff subsequently reported that Brennan expressed some warmth and concern about his grandmother, and that this was expressed in a spirit of concern rather than aggression or irritability. Unhelpfully however, why he was concerned is not recorded. The notes do evidence Brennan's irritation towards his father, and about clutter and untidiness in Sofia's house.

5.144 The independent team who undertook the Mental Health Homicide Review concluded that formal and informal risk assessments were made appropriately, and there was no reason to believe his grandmother or father might represent a target for harm. Staff thought the incursion into Sofia's neighbours home on 31 May 2020 where the neighbour was slightly injured, was because he could hear people trapped in the walls and he had only pushed past to rescue them, he had not targeted them specifically.

5.145 Regarding risk to others; Brennan was recorded as expressing no threats or animosity towards family members or others. It must be noted that he assaulted another patient when he was in hospital, however, this was before his mental health improved with medication which enabled him to be discharged. In hindsight it should be noted that later after arrest, treatment, and transfer to prison, following two violent assaults on prison officers Brennan was shown to be a risk to others, especially when non-compliant with medication.

c) Were risk assessments shared with family members?

5.146 The Trust IMR confirms risk assessment, or rather the resultant risk management plan was not shared with family. However, the Early Intervention Team advised Brennan's father to seek support from the Police if needed when he contacted them on Brennan's return from Manchester. This he did in the evening which preceded the fatal fire in the early hours of the morning, and the Police attended Sofia's home.

5.147 The Mental Health Homicide Review explained family members, or Brennan's father as his named next of kin, were not given copies of the risk assessment and it would be unusual to do so. Brennan was an adult by this time, therefore parental responsibility did not apply. Nevertheless, the Review team saw evidence that information was shared with Brennan's father when he attended ward meetings at the hospital, and when he met with the consultant psychiatrist from time to time. It is clear that the hospital was in contact with his father as Brennan's discharge from hospital was delayed by a few days so that his father could be at home. The Review team also observed the Early Intervention Team care coordinator electronic record contained notes of multiple telephone calls with his father confirming that he could contact the Team if necessary, which he did.

5.148 The Mental Health Homicide Review reports it would not be usual to meet with extended family, but the Review team felt it would nevertheless have been preferably for services to have more information about them, which they did not.

d) Did the service assess the perpetrators residential circumstances? This should include whether the service was aware that the perpetrator was living in the home of his vulnerable grandmother and was she consulted as part of the assessment process? If not, why not?

5.149 This question will be addressed under Term of Reference 18 below.

e) Were family members made aware of how to manage the perpetrator's behaviour and any contingency plan for emergencies?

5.150 The Early Intervention Team consultant psychiatrist met with Brennan's father to explain the service and provided appropriate telephone numbers in the event of a crisis. Information was provided to ensure Brennan was encouraged to desist taking illicit drugs or alcohol to excess, and to continue with his medication. The detail of the information regarding what practical steps could be taken is not known. The Trust's initial investigation noted that the Trust's risk assessment forms did not contain details of the steps to take in the event of a crisis; meaning there were no contingency plans that could have been shared with involved services and relevant parties or carers. This has resulted in a recommendation for the Trust. Sofia was not included in any information. No other family members were aware of Brennan's episode of mental ill-health; indeed, other family members were unaware that Brennan was staying in Sofia's home, and services had no information about other family members from Brennan or from his father.

5.151 Brennan's father reported to the chair that he has a very different perception with regard to being provided with phone numbers. He only had the Early Intervention Team reception number (office hours) and 999-emergency number. The Care Coordinator had a 'No user ID" number, so he could not contact her without going through the Team reception. He has no recollection of any out-of-hours numbers being shared with him.

5.152 The fact that the Early Intervention Team kept Brennan's case open despite him leaving their area enabled an open line of communication to continue as demonstrated by a number of calls by Brennan's father's to the Team in November 2020 to discuss his concerns about Brennan at university. Brennan also had contact with the Team whist he was in Manchester. Brennan's father was recommended to phone the emergency services on 999 if he felt there was a risk to himself or others. It was also suggested to Brennan's father that if there were concerns about Brennan returning to his grandmother's address and having Covid-19, then possibly using his own property for Brennan to stay[73] in or using a hotel may be a further option. This was sound advice, as Sofia's health conditions put her at enhanced risk of adverse effects should she contract Covid. That enhanced risk to Sofia should not be underestimated as Brennan was returning from an area with high infection rates which was under additional levels of movement restriction. At this time hotel accommodation in Norfolk was also severely restricted due to Covid rules.

5.153 Brennan's father also called the care coordinator in December 2020 when Brennan unexpectedly returned to Sofia's home despite the Covid risks this carried. There is a sense that this call was perceived differently by the caller, Brennan's father, and the call taker. Brennan's father asked that Brennan be assessed and in a communication for the initial Serious Incident inquiry by the Mental Health Trust some months after the fatal incident, he reported that he had asked for the assessment as soon as possible and had felt let down, given his previous calls that an appointment was offered some days later. As will be seen in the chronology (paragraphs 3.87 and 4.9), the Early Intervention Team records of this call noted that Brennan's father 'could not identify any odd or concerning behaviours, other than the possibility that he had spent money excessively possibly gambling as he had done this before, and he had 'unrealistic study options'. When discussed with the clinician for the inquiry the clinician recalled no acute concerns were communicated during the call related to presentation or risk. The clinician stated had further concerns been apparent an appointment could have been arranged sooner or further options discussed. The clinician did not recall an appointment being requested as soon as possible.

5.154 Whilst advice was clearly given verbally to Brennan's father there does not appear to have been a formal contingency plan. Nor are details apparent about how to manage Brennan's behaviour which appears to have been challenging even when he was not mentally unwell,

[73] Brennan's father informed the chair that someone else was living in his apartment at this time.

especially in light of the distant and difficult relationship between Brennan and his father. The Mental Health Trust Serious Incident Investigation observed contingency plans within care plans should be shared as required with involved services and relevant parties or carers. In this case contingency planning should have been more robust, with additional information related to this shared with the family, and a recommendation has been made concerning this. The crisis and contingency section of the care plan had not been completed, but there was generic guidance within other sections. The fact that Brennan missed two appointments with the Early Intervention Team before leaving for Manchester impacted on the gathering of information for the care plan. The recommendation made concerning contingency planning is endorsed by the Mental Health Homicide Review, Mental Health IMR and this DHR.

5.155 An audit of contingency plans was undertaken on 8 April 2022 and plans were found to be 92% compliant. The action on this recommendation was completed on 31 December 2021. This process will continue as part of the Trust's routine monitoring.

5.156 This Review believes it is also important that written contingency plans are worded in plain English avoiding professional jargon to enable family/carers to fully understand the steps to take when required. It would also be helpful, and to avoid misunderstandings, if guidance could outline for family/carers the type of information required when reporting serious concerns.

Internal Trust Review Recommendation:
Contingency planning within care plans should also be shared as required with involved services and related parties/carers.

Review Recommendation:
Contingency plans should take a 'Think Family' approach and be shared with related parties/carers having been written in plain English and avoiding professional jargon to ensure it is accessible to enable families and/or carers to fully understand the steps to take when required. This should include relevant contacts and phone numbers, and guidance on information required when reporting serious concerns.

f) What monitoring was put in place to ensure the perpetrator was complying with his medication? What alerts or actions were triggered when Brennan's father raise his concerns that he suspected Brennan was not taking his medication, due to the erratic content of Brennan's phone calls?

5.157 Brennan was monitored by the Early Intervention Team between discharge from hospital in mid-June to early September 2020 when he left Norfolk for the University of Manchester. During this time there was one home visit on 26 June at which Brennan's father was present which was preceded by a phone call on 19 June. Brennan phoned the Team on 29 June and was invited into the office for an ad-hoc visit. Follow-up visits took place to the Team office on 1, 15, and 29 July 2020, this included a medication review. The 1 July meeting was attended by Brennan's father. Brennan was followed up with phone conversations when he two missed appointments. The consultant psychiatrist had planned to review Brennan before he left for Manchester. The Team became aware that Brennan was not concordant with his medication as he left for the University of Manchester. At this stage his mental health appeared to have been stable since his discharge from hospital.

5.158 There was telephone contact with Brennan by the Team on 1 October 2020 after he started at the University of Manchester when he confirmed he had run out of medication and was not keen to take it any longer. By this time Brennan was out of area and no longer under Section to enable any enforcement action to be taken. He was phoned and texted to seek his permission to contact the university welfare team, but Brennan refused. His

Manchester GP Practice was alerted that he was out of medication. The Early Intervention Team had completed the necessary paperwork for the University of Manchester advising them of Brennan's mental health to enable him to access additional support. This was sent to Brennan but not handed into the university by him.

5.159 When Brennan's father contacted the Early Intervention Team in early November 2020 raising concerns that Brennan appeared to be no longer interested in his course, and it was reported his mother was worried that he looked thin, he was recommended to contact student support which he did. Brennan's father reported to the chair that he was unaware that Brennan had been discharged from the Early Intervention Team due to his move out of area to Manchester. Brennan had declined to give consent for information to be shared with his father, as he had for the Team to transfer him to Manchester services .

5.160 The actions taken as a result of Brennan's father's contact with the university are reported under the University of Manchester's specific Terms of Reference. The actions were not known to the Early Intervention Team.

g) Were Mental Health Services aware of the perpetrator's previous history and from whom was this obtained? If from the perpetrator were steps taken to verify the accuracy of the information?

5.161 Mental Health Services obtained Brennan's previous history predominantly from his father. Contact with Brennan's mother was via Brennan himself whilst in hospital on Section 2 and an interpreter was offered. However, his mother was unable to provide any medical records to corroborate his history. During the Police investigation the Thai Police were contacted, however, the only information provided was that Brennan was committed to a health facility for what they termed 'a minor incident'.

5.162 Had contact with Brennan been of a longer duration the Early Intervention Team would have contacted his mother to establish his early history, if he had consented.

h) Given that substance misuse, including cannabis use by the perpetrator was a factor, was the impact on his mental health of cannabis and other illicit substances given sufficient weight when assessing risk to others, and was referral to a drug and alcohol service considered or made for the perpetrator?

5.163 Brennan's initial diagnosis when assessed in hospital was 'transient psychosis with mental health secondary to the use of cannabinoids', therefore his use of cannabis from his early teens was recognised as a contributory factor. The Mental Health Homicide Review reports case notes show the Early Intervention Team discussed Brennan's substance misuse and whether it would be appropriate to refer him to the Matthew Project, a local substance misuse service. The Review Team confirmed Brennan's support from the Early Intervention Team included psychoeducation concerning the relationship between cannabis use and psychosis. Brennan had assured the care coordinator that he 'would be fine now that he'd stopped' and he did not consent to the referral. Given his refusal to accept onward referral to Manchester services his decision is not surprising. However, saying he had stopped using substances was not true; the reason he was reported missing to the Police by his father in early July 2020, was recorded as due to an argument with Sofia about him smoking 'weed'. Towards the end of July, he admitted to the Early Intervention Team staff that he had continued to smoke cannabis 2 to 3 times a week and to drink alcohol even though he had been advised of the consequences for his mental health by the Team's psychoeducational intervention. Brennan clearly decided to ignore this advice.

5.164 The Mental Health Service IMR points out the Team had only met Brennan four times and had not yet had the opportunity to formulate his individual care plan and risk assessment

where substance misuse would routinely be considered, although risk was discussed at his medical review on 29 July 2020. One would expect that risk would be discussed at an earlier stage, but it was believed he was no longer living in Sofia's home at this time but staying in a hotel or B & B, hence his home circumstances were not fully assessed. Also, Brennan was noted to be less communicative when his father attended appointments which he did on two occasions, once in the home and once at the Team premises. Brennan missed further appointments as previously discussed; he was followed up on the phone, but this indicates a degree of ambivalence by Brennan to the support being offered.

5.165 The Early Intervention Team were hampered in their further detailed assessment of Brennan by his departure for university. The Team followed a NICE guidance[74] recommendation by keeping in touch with Brennan. It was an example of good practice that despite moving out of area, the Team kept telephone contact with him during his first two months in Manchester and kept his case open if or when he returned to Norfolk. However, once discharged from his Section there were no legal means of forcing his engagement with services or enforcing compliance with his medication. The Mental Health Homicide Review observed many young people find maintaining a regular medication regime difficult or unwelcome, and this appears to be true of Brennan. However, it would have been good practice to update his risk assessment given non-compliance was an identified risk factor on discharge in order to make this visible to a practitioner in future, but this did not happen as it should.

5.166 As mentioned above, there was insufficient time with Brennan to get to know him and fully assess risk to others. His discharge location had been informed by information from his father, not Sofia. Given Brennan's diagnosis had an in-depth risk assessment been undertaken one would expect this to be informed by research which identifies risk to others associated with the use of cannabis at a young age and links to early onset psychosis. For example, the Dunedin (2002) research[75] of a large cohort from birth which supports the findings of another earlier large study[76], finds whilst there may yet to be an emphatic causal link, there is an association between cannabis use and an increased risk of experiencing schizophrenia symptoms, and younger cannabis users may be most at risk as their cannabis use becomes longstanding. More recent studies[77] suggest there is a causal connection between cannabis and psychosis. In the Dunedin study of those using cannabis by 15 years old a tenth developed schizophreniform disorder by the age of 26 compared with 3% of the remaining cohort. The risks identified were specific to cannabis use. One theory offered is that cannabis use has stronger effects on developing brains and this leads to a stronger association with future psychoses[78]. Recent systematic reviews[79] have consistently found it is the frequency of cannabis use (e.g., at least weekly),

---

[74] Recommendations | Coexisting severe mental illness and substance misuse: community health and social care services | Guidance | NICE (paragraph 1.6.1)

[75] Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, Moffit T E, "Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study" BMJ. 2002 Nov 23; 325(7374): 1212–1213. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135493/#B4

[76] Zammit S, Allebeck P, Andreasson S, Lundberg I, Lewis G "Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study" BMJ. 2002 Nov 23; 325(7374): 1199. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC135490/

[77] Miller, N.S., Ipeku, R. and Oberbarnscheidt, T., 2020. A Review of Cases of Marijuana and Violence. *International Journal of Environmental Research and Public Health*, [online] 17(5), p.1578. https://doi.org/10.3390/ijerph17051578.

[78] Pearson, N.T. and Berry, J.H., 2019. Cannabis and Psychosis Through the Lens of DSM-5. *International Journal of Environmental Research and Public Health*, Cannabis and Psychosis Through the Lens of DSM-5 - PMC (nih.gov)

[79] Robinson, T., Ali, M., Easterbrook, B., Hall, W., Jutras-Aswad, D., & Fischer, B. (2022). Risk-thresholds for the association between frequency of cannabis use and the development of psychosis: A systematic review and meta-analysis. Psychological Medicine, 1-11. doi:10.1017/S0033291722000502. Risk-thresholds for the association between frequency of cannabis use and the development of psychosis: a systematic review and meta-analysis | Psychological Medicine | Cambridge Core.

notably from a young age, which appears to be associated with an elevated risk of psychosis, and this risk is likely to be further influenced by other risk-factors (e.g., genetics, family history, cannabis potency). Brennan reported using cannabis from the age of 14 or 15 years old.

5.167 Whilst acknowledging the challenges and limitations faced by the Mental Health Team trying to engage Brennan in a relatively short period of time, the research cited here has relevance for the future. A primary aim of a DHR is to prevent similar homicides in future and increase learning, hence it is important that professionals (and not just mental health professionals) are aware of the negative impacts of cannabis use at a young age, a drug which can often be viewed as an innocuous, benign substance, which may be tolerated socially.

5.168 The Dunedin study cited above found young male cannabis users were nearly 4 times more likely to be violent than non-users. Miller et al[80] suggest current marijuana is far more potent in THC concentrations, the psychoactive component, and direct studies demonstrate more potent marijuana results in a greater risk for paranoid thinking and psychosis which manifests itself via increased aggressiveness, paranoia, and personality changes (more suspicious, aggression, and anger). Reviews of research[81] into the links between violence and cannabis use are not conclusive due to inconsistencies in methodology and cohorts used, however, for patients with severe and persistent mental illness or histories of violence, research found it is critical to curb cannabis use given the stronger associations between cannabis use and violence within that cohort. For instance, in patients with recent-onset psychosis, reductions in cannabis exposure were related to improvements in patient functioning as assessed with the Global Assessment of Functioning Scale[82]. Some studies suggested a withdrawal from cannabis may result in increased irritability and aggression.

5.169 For context the 2021 analysis of UK Domestic Homicide Reviews (DHRs)[83] found of 113 DHRs where the relationship was stated, 27% were familial homicides. A detailed analysis of 66 adult family homicide DHRs[84] identified five interlinked precursors of which perpetrators with mental health difficulties predominated (78.8%), of these 53% of the perpetrators had a diagnosis of psychosis and mood disorders. 39.4% had mental ill-health and substance misuse problems. 90.9% of the familial homicides were committed by a male perpetrator. The author of this report notes that of the DHRs she has undertaken (both intimate partner and familial homicides) heavy and long term cannabis use by the perpetrator featured in 41% of the Reviews, and of these homicides 66% of the perpetrators had a diagnosis of psychosis at the time of the crime. An analysis of DHRs

---

Published online by Cambridge University Press: 24 March 2022. Risk-thresholds for the association between frequency of cannabis use and the development of psychosis: a systematic review and meta-analysis | Psychological Medicine | Cambridge Core

[80] Miller, N.S., Ipeku, R. and Oberbarnscheidt, T., 2020. A Review of Cases of Marijuana and Violence. *International Journal of Environmental Research and Public Health*, [online] 17(5), p.1578. https://doi.org/10.3390/ijerph17051578.

[81] Dorsa Rafiei and Nathan J. Kolla "Fact or Faction Regarding the Relationship between Cannabis Use and Violent Behavior". Journal of the American Academy of Psychiatry and the Law Online December 2021, JAAPL.210034-21; DOI: https://doi.org/10.29158/JAAPL.210034-21

[82] The Global Assessment of Functioning (**GAF**) is a scoring system that mental health professionals use to assess how well an individual is functioning in their daily lives. This scale was once used to measure the impact of psychiatric illness on a person's life and daily functional skills and abilities.

[83] Home Office (September 2021) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews prepared by Analytics Cambridge & QE Assessments Ltd. Domestic Homicide Reviews (publishing.service.gov.uk)

[84] Bracewell, K., Jones, C., Haines-Delmont, A., Craig, E., Duxbury, J., & Chantler, K. (2022). Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide, *Journal of Gender-Based Violence*, *6*(3), 535-550. Retrieved Jan 2, 2023, from https://bristoluniversitypressdigital.com/view/journals/jgbv/6/3/article-p535.xml

by the domestic abuse charity Standing Together[85] found mental health problems were identified in 64% (16/25 cases) of perpetrators in Adult Family Homicides, with 56% (14/25 of the cases) of the perpetrators diagnosed with a psychotic disorder, of these 40% were open to mental health services at the time of the murder.

5.170 A meta-analysis by Fazel[86] highlighted the importance of risk assessment and management for patients with a comorbidity of mental ill-health and substance abuse. The Royal College of Psychiatrists 'Good Practice Guide'[87] to risk assessment includes 'Alcohol or substance use, and the effects of these' (page 6) in history to be considered. It is also encouraging to see listed 'Are the family/carers at risk? History of domestic violence'. All the context of a patient's life, family background, relationships, plus stressor points, need to be factored into risk assessments to give practitioners the information they need to inform decisions and risk in such cases.

5.171 Admittedly the picture is complex; and it must be stressed not everyone with a mental illness will be violent, nor is it suggested that all those experiencing a psychotic illness become violent; a majority of people living with and managing this condition effectively with the support of services will not be violent; indeed, they are more likely to be a victim of violence[88]. Nor will all misuse of substance cause violence. However, the above research findings are pertinent for consideration in this and similar cases where significant cannabis use has started in a service user's early teens, especially where the service user is non-compliant with medication or ambivalent about the support offered. The co-morbidity of mental ill-health and substance misuse needs to be seen as an additional risk factor especially in this cohort. The research discussed here is not alone in its findings regarding the links between cannabis and various degrees of psychosis, but for brevity others are not cited here (see Pearson & Berry 2019 cited in this report). This has relevance not just for Mental Health Services, but Substance Misuse, Health, Public Health, and Social Care services also.

5.172 Analysis of DHRs[89] reveals 40% of perpetrators were attending a number of different services, and of these 37% were for mental health issues, 28% Probation supervision, and 21% for drugs and alcohol. Fifty four per cent of the total attendances for familial abuse perpetrators was for mental health issues compared to 32% of intimate partner perpetrators. This indicates the importance of considering these issues in risk assessments.

Recommendation:
When services become aware during assessments that a person has continuously used cannabis from their early teens and they develop early onset psychosis symptoms, this should be factored into risk assessments. This is essential in cases of poly-substance misuse co-morbidity to ensure assessments are robust in assessing risk to others as well as risk to self.

[85] Executive Summary London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process (October 2019) Standing Together Against Domestic Violence. Mayor's Office for Policing & Crime Standing+Together+London+DHR+Review+-+Executive+Summary.pdf (squarespace.com)

[86] Fazel S. et al (2009) 'Schizophrenia and violence: systematic review and meta-analysis' PLOS Medicine, Vol 6: Issue 8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2718581/ Accessed 21.01.19

[87] Royal College of Psychiatrists (2016) '*Assessment and management of risk to other. Good Practice Guide'* (August 2016) assessmentandmanagementrisktoothers.pdf (rcpsych.ac.uk)

[88] Khalifeh H, Johnson S, Howard LM, Borschmann R, Osborn D, Dean K, Hart C, Hogg J, Moran P. Violent and non-violent crime against adults with severe mental illness. Br J Psychiatry. 2015 Apr;206(4):275-82. doi: 10.1192/bjp.bp.114.147843. Epub 2015 Feb 19. PMID: 25698767. Violent and non-violent crime against adults with severe mental illness - PubMed (nih.gov)

[89] Analysis of Domestic Homicide Reviews October 2021- September 2022 (awaiting publication)

Recommendation:
The Department of Health & Social Care should consider a public health awareness raising campaign for secondary school aged children and young people with the aim of highlighting the negative impact on mental health of early and frequent cannabis use.

Term of Reference 16: *Why were family members, other than Brennan's father, including Sofia's Lasting Power of Attorney, not made aware that Brennan had mental health issues, had been Sectioned for violent behaviour and was staying at his grandmother's house?*

5.173 The Mental Health Homicide Review and other investigations into the various parts of the Mental Health Service's involvement found NHS staff had no knowledge of the wider family nor their level of awareness of Brennan and his mental ill-health. Case notes were found to be silent on any other family, including Sofia. There was no awareness that Brennan's grandmother had Lasting Power of Attorney arrangements.

5.174 There was no basis to share information about Brennan's mental health with a third party, other than his father as next-of-kin during the period of time when Brennan lacked mental capacity prior to treatment. Indeed, Brennan declined to share information with his father once he regained capacity.

5.175 The independent Mental Health Homicide Review concluded it would have been for Brennan's father, as next-of-kin, to communicate the facts to his family, especially as he had been providing support for Sofia who was frail. However, there is no evidence that Brennan's father was asked whether Sofia agreed with Brennan returning to her home, or that he sought her views before Brennan was discharged.

Term of Reference 17: *Following the perpetrator's move to the University of Manchester, was the transfer of information to relevant services in that area undertaken effectively and were there any barriers which affected the provision of ongoing mental health support to him.*

5.176 As is evident from the chronology of this report, once the GP practice was known with whom Brennan had registered, the Early Intervention Team sent a letter on 14 October 2020. This advised that he had ceased his medication and had declined an onward referral to the Early Intervention Service in Manchester, however he was stable and symptom free since hospital discharge. Nevertheless, the letter warned there was a risk of deterioration due to ceasing his medication and it was recommended that he be referred on if his mental health did deteriorate. This letter, coupled with Brennan's transferred GP notes, was effective in transferring relevant information to his new GP practice. It was also made clear that Brennan would remain open to the Early Intervention Team if he returned to Norfolk. However, due to Covid restrictions new patient appointments were not taking place, therefore the Manchester GP did not meet Brennan.

5.177 The GP practice was the service with whom information could be shared. The primary barrier which affected ongoing mental health support for Brennan was Brennan himself. He was no longer under Section and therefore unable to be treated without his consent; in the period after hospital discharge he had mental capacity to make decisions. He had been given information regarding the fact that drugs could trigger another psychotic episode, but as is highlighted in the Mental Health Homicide Review, he was no longer under any obligation to comply with his treatment and in common with many young people did not like taking tablets making it difficult to sustain regular medication.

5.178 An additional barrier was Brennan's refusal to consent for the Early Intervention Team to refer him to Manchester Mental Health Services or to contact the university student support

services. He was an adult at this time and grounds for sharing information without his consent were not met due to patient confidentiality, and an absence of any safeguarding concerns, or violence to others at this time.

Term of Reference 18: *When the perpetrator was discharged from hospital under Section 2 of the Mental Health Act 1983 in the summer of 2020, was his suitability for discharge effectively assessed? Was the location to which he was discharged assessed or considered? Were there any resource issues which influenced the discharge decision?*

5.179 Once treated with medication in hospital Brennan's symptoms improved very quickly, thus after assessment by the hospital team, including his consultant psychiatrist, he was deemed medically fit for discharge. The psychiatrist discussed the plan with Brennan's father by telephone the day before the discharge meeting, and arrangements were made to discharge him on Thursday 18 June 2020. There was a slight delay in arranging this to fit in with his father's arrangements to ensure he could be at home to receive Brennan. As reported in paragraph 3.65 of the chronology, Brennan's father had a different perception of what was said and planned at the time of discharge and when this would take place. He reports being surprised by Brennan's arrival.

5.180 There is no evidence that Brennan was discharged earlier than was appropriate due to a shortage of resources within the hospital setting, or in the community where mental health support was required after discharge and which was provided as planned. Brennan was followed up by phone the day after discharge by his community Early Intervention Team care coordinator, and a face-to-face meeting with Brennan at home took place on Wednesday 24 June as planned. The independent Mental Health Homicide Review team does not believe there were any resource issues which affected the decision. It was made on medical grounds due to Brennan's positive response to his treatment. The resource issue had been a hospital bed for admission, and this had been addressed (see Term of Reference 10).

5.181 Section 2 of the Mental Health Act under which Brennan was held in hospital enabled him to be admitted for treatment for up to 28 days. It is important to note the wording *"up to"* 28 days. If a patient is judged to be successfully treated before 28 days are completed, then they may be discharged. The first of the 'Five Overarching Principles' within the Mental Health Act 1983 Code of Practice[90] is the '*Least restrictive option and maximising independence'* principle which states*:*

- *If the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available.*
- *Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained.*
- *Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.*

5.182 When examining the electronic notes for Southern Hill Hospital where Brennan was treated, the Independent Mental Health Homicide Review team found evidence that staff had discussed Brennan's home circumstances including in a conversation with his father. The notes show that the team judged Sofia not to be at risk although no formal safeguarding assessment was completed to understand how this lack of risk to Sofia decision was reached.

5.183 It is of note that discharge meeting notes when referring to follow up in the community arrangements refer to a visit at "his father's home". There is no recognition that it was

[90] Mental Health Act 1983 Code of Practice (published 2015) page 22: Mental Health Act 1983 (publishing.service.gov.uk)

Sofia's home, that she should have been consulted about the plan to return Brennan, and it should have been established whether she agreed with the plan. It is as if Sofia was invisible; her status as the home owner was not recognised, and she was not consulted independently on her own as she should have been to consent or decline Brennan's return.

5.184 The second of the Overarching Principles in the Mental Health Act Code of Practice is '*Empowerment and involvement*' which requires that patients are fully involved in decisions about their care, support, and treatment. It also includes '*The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this'.* However, the detail of this Principle includes *'Patients should be encouraged and supported in involving carers (unless there are particular reasons to the contrary). Professionals should fully consider their views when making decisions'* (1.11 page 24) which has the effect of diluting the requirement to involve family and carers. In this case the view of 'family' was too narrow; only Brennan's father was considered, not the views of Sofia the other resident and owner of the house to which he was discharged. This was a very significant oversight. The care coordinator saw Sofia briefly in the hallway at the time of the home visit but did not speak to her. This was both impolite and a missed opportunity to speak to her independently and seek her views.

5.185 The Mental Health Homicide Review is of the opinion that greater care should have been taken in relation to Sofia before Brennan was discharged to her home. Whilst risk associated with abuse and neglect should not automatically be associated with a person's age or memory problems, the Review Team believe it would have been sensible to complete a safeguarding assessment to consider the impact upon Sofia of Brennan's return to her home. The DHR chair and Panel concur with the view that when Brennan was discharged from psychiatric hospital to Sofia's home, greater care should have been taken in relation to the risks potentially presented to Sofia who was vulnerable, frail, and experiencing memory and hearing problems. The Review Team believe that a formal safeguarding check by NHS staff could have been undertaken to bring more clarity to the home situation. The Mental Health Homicide Review Team believe assessment of Brennan's mental health needs would have been strengthened if more detailed information had been obtained from his family, including his mother, when he was first admitted. The chair and DHR Panel would explicitly include his grandmother in this information gathering process since she had witnessed Brennan's behaviour at first hand. This requires assessments which take a 'Think Family' approach, which the Mental Health Homicide Review Team also recommends. This should be coupled with professional curiosity to obtain an in depth background and history of the service user's prior behaviour.

5.186 The Mental Health Homicide Review Team also reviewed care planning and risk assessment recording processes and observed the Trust has a new evidence based system in the process of roll-out at the time of writing. The Review Team have made the recommendation below regarding this.

Mental Health Homicide Review Recommendation:
That the Mental Health Trusts roll-out of DIALOG and DIALOG+ system be maintained and reviewed, and in due course audited to ensure social, cultural, familial, and other patient -based information can be built into care in Norfolk more effectively.

Recommendation:
All local health inpatient and residential social care providers: To review, and revise where necessary, the provider's Discharge Policy to ensure it covers consideration of vulnerable persons residing in the accommodation the patient/service user is returning too; specifically in respect of any risks to others the returning patient/service user may pose to other occupants. *(This is expanded further in the Recommendations section)*

Recommendation:
All services undertaking assessments should take a 'Think Family' approach and use their full assessment skills and professional curiosity to ensure information for care plans and risk assessments is fully inclusive of all family members and family structure, plus any carers, and where relevant note who is the home owner or holder of a tenancy.

The Police:

Term of Reference 19: *When attending the incident between Brennan and his father on the night preceding the fatal fire were the officers fully informed enroute of the family situation, and did two of the officers recognise their previous involvement with the perpetrator in May 2020 which resulted in his detention under the Mental Health Act? If not, why not?*

5.187 As described in the chronology officers were given information enroute by the call handler and that an immediate response was required. Officers were told the call handler was still on the line to the informant (Brennan's father), that his 19 year old son was being violent towards him – suspect given as Brennan, and Police had not been to the address since July (when Brennan was reported missing by his father). The call handler indicated to the officers that they were having difficulty obtaining information from the informant. In the 999 recording Brennan's father sounds agitated and stressed and the call taker struggled at times to obtain answers to the questions they needed to ask. Brennan's father did include the fact that Sofia was also at the address; he did not report that she had also been a victim or impacted by Brennan's behaviour. The focus was his concern that Brennan was threatening him and acting strangely. The officers arrived at the address quickly and before the call handler had passed on further information. Brennan's father explained to the chair at the time of making the 999 call he was in genuine fear of being imminently physically assaulted by Brennan who was standing only one foot away from him. His level of fear and anxiety is likely to have affected the delivery of the information he was trying to impart during the call.

5.188 Sergeant A and officer B were both aware they had attended the address before and of Brennan's mental health history in May; officer B had been one of the officers who escorted Brennan during the process of his detention under the Mental Health Act. Sergeant A had submitted the risk assessment for the May incident, as they did for the December attendance.

Term of Reference 20: *Did the officers recognise the incident as domestic abuse related and was a DASH[91] or other risk assessment undertaken? If so, what risk level was calculated and what decision was made as a result?*

5.189 Attending officers in December 2020 did recognise the incident between Brennan and his father as domestic abuse related as evidenced by the record made on the Athena Police database which shows a Non-Crime Domestic Abuse Investigation entered at 01:05hrs. A DASH risk assessment however was not undertaken as the Norfolk Constabulary policy does not require this for a non-intimate relationship incident i.e., familial abuse. Instead, risk was assessed under the 'Adult Protection Investigation' process which was completed at 01:24hrs regarding safeguarding concerns for the parties involved. This is based on professional judgement. The assessment was In relation to Brennan and his mental health and was recorded as 'medium' level of risk i.e., he was calm, not exhibiting overt signs of mental distress, and there appeared to be no immediate signs of threat to life. This

[91] DASH – Domestic Abuse, Stalking & Honour Based Violence risk an evidenced based assessment checklist used to assess the level of risk faced by victims of domestic abuse.

information was forwarded at 03.47hrs to the MASH Adult Safeguarding for a secondary risk assessment and Norfolk Constabulary Mental Health Team. Sadly, due to the timing of events these tasks were not reviewed by MASH until after the fatal event.

5.190 No risk assessment was completed assessing risk to Brennan's father who was the complainant. The Constabulary's policy is not to use the DASH for familial domestic abuse cases, but instead undertake an Adult Risk Assessment, this system seems to have had the effect of taking the focus off the alleged victim who called for help. Because Brennan was previously known by officers to have been Sectioned, he appears to be seen as the person requiring a risk assessment, not the person reported to have felt threatened by him and who was clearly anxious during the incident. Whilst recognising no criminal offences could be identified to bring about action that night, it would have been appropriate for officers to also undertake a risk assessment for Brennan's father as the complainant and a previous victim of assault by Brennan. On this basis it would be advisable for the Constabulary to review its policy regarding how risk is assessed in family domestic abuse incidents to ensure focus is not lost on the complainant/alleged victim.

Recommendation:
That Norfolk Constabulary examine its policy on risk assessment in cases of familial domestic abuse incidents to ensure the focus on the alleged victim/complainant is not lost, and officers are supported in their professional judgement in assessing risk in such cases.

Term of Reference 21: *When attending the December 2020 incident were the police aware that a vulnerable elderly woman was resident in the property who might be at risk, and what steps were taken to speak to the victim herself to assure her safety and wellbeing, and to provide reassurance given the disturbance which had taken place between Brennan and his father? If not, why not?*

5.191 Officer F's body worn video footage shows the officer with Brennan's father on the upstairs landing and as they turn to go downstairs, Brennan's father nodded towards a closed bedroom door and said, "*my mum's in there she can't hear anything I'm afraid."* Other than this there is no mention made of Sofia or any concerns he may have had relating to her. Therefore, officer F was aware of Sofia's presence in the house, and the IMR confirms sergeant A also knew but their view was under the presenting circumstances, it was unnecessary to check on Sofia and may have caused her distress to do so. This view was shared by officer B.

5.192 The focus of officers attendance was Brennan and his father, who appeared to be quite anxious and with whom time was spent discussing options for Brennan leaving the property. No criminal offences were alleged to have been committed i.e., assault, criminal damage etc hence officers had no grounds to remove Brennan, and he was not considered a threat to any other person. The incident appears to be perceived as an argument between father and son over a phone and charger, instead of Brennan's father feeling under threat from his son, and as there was no suggestion from either Brennan or his father that Sofia was involved in or had witnessed the incident as she was in bed in her room, officers assessed there would be nothing to gain by waking her at such an unreasonable hour. Officers were unaware of Sofia's age and physical frailty; all they knew from Brennan's father was she was deaf and therefore would not have heard anything. Further probing about Sofia could have been made to discover whether another resident should have been considered as an adult at risk due to her health vulnerabilities. As previously discussed at paragraph 5.16, there is an argument to be made that consideration should be given to seeing vulnerable elderly adults as well as children when attending domestic abuse incidents.

Term of Reference 22: *Did the police consider making a vulnerable persons referral to Adult Social Care in light of Sofia's presence in her home at the time of officers attendance at the incident?*

5.193 The IMR confirms there is no record to show that officers considered a referral to Adult Social Care with regard to Sofia. It is clear that the attending officers understood her to be elderly and to have hearing issues, however risk to Sofia appears not to have been considered, even during the daytime attendance in May 2020 when Brennan was removed to hospital. Checking on her wellbeing on this occasion would have been appropriate even if officers were told she had not seen anything, especially given that it would be reasonable to suggest there would possibly have been some noise from the dispute taking place when Brennan was reportedly demanding his father's phone. Sofia may also have heard the extra footsteps on the stairs and officers voices outside her room and wondered what was happening. The focus was on Brennan and his father. Again, Sofia was invisible.

Term of Reference 23: *What was the duration of the officers Enquiries at Sofia's home in December 2020? Was sufficient time and open and probing questions used to explore Brennan's mental state, and on what basis did the police conclude that Brennan was not a threat to either his father or Sofia? This should include a review the body cam footage and transcript.*

5.194 The body worn camera footage shows the duration of officer's attendance as 17 minutes 29 seconds. The IMR suggests this was sufficient, however, to the lay person it may appear to be of limit duration for such a call. Officers had split their resources however, with two officers who had seen Brennan before spending the majority of this time with him, and one officer remaining with his father downstairs. All three officers were with Brennan's father at the end of the attendance.

5.195 As discussed under Term of Reference 9, appropriate and open questions were not used sufficiently when interviewing Brennan in particular. A majority of the questions enabled Brennan to give one or few word answers which were mumbled and at times inaudible or difficult to understand. Questions needed to be far more open and probing to require a broader more descriptive answer from him. The inspector who reviewed the incident and who had a previous career in mental health, stated when dealing with people who are suffering from mental ill-health it is good practice to ask how they are feeling or if they recognise anything is wrong. This would demonstrate insight into their mental health and provides a good indication into how they are thinking. Officers did not explore how Brennan was feeling. It was not helped that Brennan remained lying in bed mostly covered by a duvet. Had he been asked to sit up for the interview not only might his answers have been clearer, but his physical demeanour and body language could also more fully informed officers' assessment.

5.196 One has to take into consideration that Police officers are not mental health professionals, their training in mental health issues is not in-depth and the Mental Health Advice Team in the control room were no longer on duty at the time of their attendance, but the lack of suitable questioning of Brennan was a basic flaw in interview techniques to extract information. In interview for the IMR officer B explained "*I was constantly assessing how he presented to me, which helped me to decide whether I considered that he was a risk to himself or others and ultimately, I was not concerned. Brennan presented as calm and although he was quiet, he answered the questions I put to him."* Sergeant A, one of the other officers who spoke to Brennan said *"I did not feel that he was acting as though he was unwell or in need of the Crisis Team… compared to the previous incident that I attended, Brennan looked well, he was engaging with us although quietly spoken and slightly awkward, but I had no concerns or felt the need to call the Crisis Team. He did not appear aggrieved or violent".* The body camera footage confirms the officer's description of Brennan when they were with him.

5.197 It was on this basis, plus the fact no criminal offences or disturbance could be identified, and a protective factor was present in the form of Brennan's father who had been given advice to call the Mental Health Crisis Team, that the officers took the decision they did. The sergeant confirmed all three officers concluded there was nothing they could do that night and had any of the officers disagreed they would have had a private discussion. The IMR formed the opinion that it may have been reasonable to expect any escalation in behaviour by Brennan would result in another 999 call to the Police, and officers had no reason to believe that this protective factor would not be present throughout the night.

5.198 It was emphasised to officers by his father that Brennan was highly intelligent and able to manipulate doctors, and one might ask could officers have been manipulated by Brennan to appear well, or could they have been correct in their assessment that Brennan was not mentally unwell at the time of their visit; there is no doubt he presented very differently from when officers had seen him in May 2020 when he was definitely very unwell and had been violent. Could his actions that followed have been taken knowingly and not affected by mental illness, or did his health deteriorate to a psychotic episode sometime after officers left. His father is of the view that Brennan was experiencing a psychotic episode when he called the Police, but without a mental health assessment at the time it is impossible to substantiate this.

Term of Reference 24: *The perpetrator's father feels his concerns were not listen to by attending officers in December 2020. What did officers understand to be his concerns, if they were not clear what his concerns were what actions were taken to clarify his assessment of the situation which led to him calling the police via 999?*

5.199 From the content of the 999 call made by Brennan's father and from a review of body worn camera footage it is clear that based on his previous experience he felt threatened and he was fearful for his safety. As previously explained two of the three officers present had attended the previous incident in May 2020 and were able to compare the situations to assist their assessment. Indeed, Brennan's father referred to the previous incident and said the behaviour exhibited by his son was the same and Brennan had been removed from the address on that occasion. However, the situation presented to the officers who were there on both occasions, was very different. As stated above, Brennan appeared calm not very agitated as before, there were no signs of disturbance, and there was no report that Brennan had assaulted his father as he did in May. Risk appeared to them at that time to be lower compared to the previous incident.

5.200 The 999 call taker had taken steps to clarify the situation with Brennan's father by repeating questions to him to garner the basic facts and whether he was in immediate danger of violence whilst simultaneously dispatching officers to the address. This was necessary as Brennan's father appeared to be having difficulty expressing himself and answering questions clearly, possibly due to his level of fear and anxiety. Officers on the scene understood that Brennan's father was fearful of his son based on his previous experience. This manifested itself in his somewhat fast and halting manner of speech when answering questions and explaining what had happened, and his anxious body language and sometimes pacing around the room. In the camera footage officers can be seen asking a number of times what Brennan's father wants them to do, and it was clear that he wanted Brennan removed from the house. He was advised to call the Mental Health Crisis Team if he later felt it necessary, but they were unable to remove Brennan as there was no evidence of a crime being committed Brennan's father informed the chair, he only had the phone number for the Early Intervention Team reception and as far as he knew he had to wait until 9:00am (normal office hours) to call them. The police did not give him any contact details for the Mental Health Crisis Team. The chair is informed that Crisis Team numbers are available on the internet, but this demonstrates further the need for Mental Health

Services to provide family and/or carers with written contingency plans and relevant contact numbers.

Term of Reference 25: *Was sufficient weight given to information provided to the police by the perpetrator's father given that the police should have been aware of the perpetrator's mental ill-health from their previous involvement with him in May 2020?*

5.201 Brennan's father's information provided to officers was acknowledged by them, and as stated in addressing the previous Terms of Reference, officers were aware of the perpetrator's mental ill-health as two of them had first-hand experience of this. The difficulty officers faced was the lack of evidence of criminal offences which would enable them to arrest and remove Brennan. Nor was he showing behaviour to indicate he was mentally unwell to warrant officers calling the Crisis Team that night. Brennan's father understandably felt unable to tell him to leave the house at such a late hour with no alternative accommodation for him to go to. Had hotel accommodation not been affected by Covid restrictions which involved government directions to every Local Authority to accommodate those at risk of rough sleeping, and those suffering from Covid who could no longer live with vulnerable, shielding family members, officers may have helped by taking Brennan to the hotel where he had stayed before.

Term of Reference 26: *What assessment did the police make of Brennan's father's presenting disposition, his concerns about impending violence from Brennan, and did they understand that he felt his life was under threat hence his 999 call to the police for help?*

5.202 The 999 call indicates that Brennan's father's disposition is one of considerable anxiety; sentences are sometimes incomplete and required clarification. To indicate this a summary of the call starts:

"Please can you come I am worried. My son is behaving very strangely and I am worried. He is threatening me. Please come he is violent. He is with me here and I am worried for my safety... and my mother's safety."
(it is noted that there are no sounds of disturbance, aggression, or other persons in the background of the call)
The call handler clarifies *"when you say he is threatening you what is it that he has done?"*
Brennan's father replies *"he is verbally... I am worried... please come".*
He indicates that there are no weapons and that Brennan has mental health issues he says, *"he is with me he is staring at me".*
The call handler asked, *"where is your mother?"* and the reply is *"she is in the next bedroom but she can't hear, she is half deaf".*

5.203 Police understood the anxious disposition of Brennan's father and therefore dispatched officers to the address at 00:02:48 arriving at 00:07:11 – 4 minutes and 23 seconds as an emergency response. All officers stated that on their arrival Brennan's father presented as stressed and anxious and he was concerned he would be assaulted or have his mobile phone damaged or taken by Brennan, for example information from camera footage includes:

Brennan had been threatening him – staring at him and the last time he did that, Brennan had started to get violent.
He was frightened - when asked whether he believed he was about to be assaulted, he said it was what Brennan had done before. He said he had not been hit on this occasion.
He was scared and said "I can hardly sleep at night; I'm worried for my life"; .
That there were knives in the address and that Brennan could kill.
Brennan's father said: "I hope I'm alive tomorrow that's all".

In light of officer's inability to arrest Brennan due to no identifiable criminal offences they tried to reassure his father that Brennan was in bed, had agreed with officers that he was going to sleep and was not going to speak to him. However, this reassurance appears to have been insufficient to allay his father's anxieties based on his previous experience of Brennan when he was mentally unwell.

Term of Reference 27: *Did officers make a contingency plan with Brennan's father before leaving the property in case his concerns escalated? If so, did this include evacuating the property if necessary, and was consideration given to involving out of hours support services such as Mental Health Services.*

5.204 Officers discussed contacting the Mental Health Crisis Team with Brennan's father and learnt from him that he had called the Mental Health Team previously and an appointment had been given. They informed him that he could call the Crisis Team again and suggested that he do so if Brennan was failing to take his medication.

5.205 The officers advised, in the absence of a lock that he put something against his bedroom door, keeping apart from Brennan, and contacting the Crisis Team and council [housing department] in the morning (some 7 hours later at that point). Officers remained in the house for a short time after Brennan's father went upstairs and he was heard to move something in the room. They exited the address once it was clear that he was in his room and there were no ongoing threats or aggression from Brennan. Similarly with the style of questions asked of Brennan, it would have been helpful if officers had asked Brennan's father about his ideas for keeping himself safe, If one of his strategies had included leaving the house this could have been discussed, and importantly his mother's safety could also have been discussed.

5.206 Officers judged there was no indication from Brennan's presentation that he required the intervention of the Crisis Team that night, and there was no evidence of any threats made or behaviour which indicated the evacuation of the property was necessary.

Term of Reference 28: *To provide an explanation for the perpetrator's father regarding why Brennan was not arrested or evicted from the house when he made this request when, in his opinion, he had provided compelling reasons (including fears of violence) to do so?*

5.207 The Police IMR explains the limitations under the law concerning their ability to remove Brennan in December 2020 namely:

> *"Police powers of arrest without warrant are covered by the Police and Criminal Evidence Act 1984 (PACE). The power to arrest a person who is involved, or suspected of being involved, in a criminal offence must be used fairly, responsibly, in a proportionate manner and consider if the necessary objectives can be met by other, less intrusive means".*

5.208 One of the criteria for arrest is "*To prevent the person causing physical injury to themselves or any other person, e.g., when the suspect has already used or threatened violence against others and it is thought likely that they may assault others if they are not arrested".* Although Brennan had used violence before against his father in May 2020 this was when he was very clearly mentally unwell, and he was diagnosed and treated for a mental illness. The Police had not seen him mentally ill since. It is understandable that Brennan's father in his fearful state thought the Police could arrest or remove Brennan in December 2020, but there was no verbal threat or action to harm or kill from Brennan, just a stare. Whilst this intimidated his father based on his previous experience, a stare was not in law sufficient to be considered a threat of violence to arrest. As mentioned previously in this report, in December 2020 Brennan was inside a dwelling, he was not trespassing and officers were unable to identify evidence of a criminal offence to arrest Brennan. Nor was

mental illness evident to warrant calling out the Crisis Team. Fuller details of the legal actions and powers available to the Police under legislation are described in Appendix 5 of this report.

Term of Reference 29: *Was consideration given to the Covid pandemic restrictions in place at the time (people were prohibited from meeting those not in their "support bubble" inside. People could leave home to meet one person from outside their support bubble outdoors.) and that the perpetrator had breached these by leaving his accommodation in Manchester to go to his grandmother's home when she was in a vulnerable group due to health and age.*

5.209 This question has been addressed in Term of Reference 6 relating to the impact of Covid restrictions.

University of Manchester

Term of Reference 30*: Confirm the timeline of Brennan's arrival and departure at the University of Manchester, and whether Brennan informed the university that he was leaving.*

5.210 The University confirmed that Brennan moved into his hall of residence on 18 September 2020 and his very limited movements in and out of the accommodation is given in the chronology. The swipe card system does not register exits; therefore, it was not possible to confirm when he left for the final time and Brennan did not inform anyone that he was leaving.

5.211 The only information available to the Review which clarifies Brennan's leaving date is a phone call to Brennan's father by the Early Intervention Team in early December 2020 in which it is reported that Brennan had returned to the local area to try and access his savings account. He had not stayed with his father at this time. This accentuates the distance in the relationship between Brennan and his father. Brennan's father understood that this was only a day return trip from Manchester to Norwich.

Term of Reference 31: *Were the university aware of Brennan's mental health history prior to being contacted by his father? If not, why not? What is the process the university has in place to be made aware of any health vulnerabilities a student may have, and what support is in place for those who require additional support and did Brennan access available support?*

5.212 The application process for the University of Manchester asks twice whether the applicant has any pre-existing and/or long term conditions, including mental health, for which they may benefit from additional support. The first is on the UCAS[92] form when applying, the second is during the university online registration. Brennan did not make any declarations during either process. He was advised to do so by the Norfolk Early Intervention Team care coordinator but chose not to do so. The Panel discussed the issue of self-disclosure concerning mental health issues in the application process and acknowledged that a person applying for a university place my not feel able to do so and may be anxious to avoid any negative impact on being offered a place. Stigma associated with mental ill-health may also cause an applicant to withhold this information, and this may be more pronounced among students from overseas where mental illness can be a taboo subject or may result in discrimination. How academic institutions resolve this dilemma is debatable; resolution probably rests with worldwide societal change in attitudes to mental health.

[92] UCAS – the Universities admissions service.

5.213 The university IMR highlights 2021 research by UCAS which estimate that 70,000 students per year may enter higher education with a mental health condition, but 49% told UCAS they had not shared this information. The IMR points out that whilst the university and UCAS take steps to encourage disclosure, it will always be a personal decision. They recognise however, that some students will remain concerned about divulging such personal information at the point of their application and starting at university.

5.214 No one in the Computer Science Department has any recollections or record of Brennan raising concerns about his mental health, past or present. However, it must be recognised that teaching moved online from the first week of his course on 5 October 2020 due to the Covid pandemic restrictions therefore face-to-face interactions affected staff's ability get to know their students in person. Brennan only attended two meetings with his tutor: week 2 commencing 12 October, and week 3 commencing 19 October. He missed subsequent meetings.

5.215 Just prior to contact by Brennan's father on 19 November 2020, concerns about Brennan's behaviour had been raised by his flatmates 3 days earlier on 16 November. They asked residential life advisor 2 for advice as they were worried and a bit scared by Brennan. The flatmates said that they knew that Brennan had a history of mental health problems and that he had been Sectioned at least once before. A report of the visit was shared with the relevant residential life coordinator who was senior to advisors 1 and 2.

5.216 At the visits to Brennan on 17 and 18 November by the residential coordinator and residential life advisor 4 only family issues and that he did not have a good relationship with his father were raised by Brennan. What the family issues were appears not to have been explored. (The relevant advisors were not available for the IMR author to interview) Brennan said he had financial issues and was thinking he may have to drop out of university and get a flight home after lockdown[93]. He was encouraged to consider an appointment with the university's Counselling & Mental Health Service or to contact the Residential Life Team, but he responded negatively to these suggestions and did not access the services available. The information provided by Brennan's flatmates on 16 November indicates that the Residential Life Team were, or should have been more aware, that Brennan had a history of mental ill health sufficiently serious to require Sectioning.

5.217 In addition to the advice given to Brennan the university website has a variety of student support services clearly signposted[94], including those for mental health and wellbeing. A description of the access to support process provided within the university's IMR is shown at Appendix 2. It includes the processes and considerations followed in the event of concerns about a student's mental health being disclosed by someone other than the student, for example, by another student, a member of staff, a family member.

5.218 It would appear that Brennan was extremely reluctant to accept support or access services at the university, and despite phone calls to the Early Intervention Team in the early part of his stay in Manchester, he decided not to access student support as they advised. He may also not have recognised his mental health was deteriorating after ceasing his medication.

5.219 The university IMR highlights that had they been made aware of Brennan's mental health history during the application or registration process he would have been assessed for support at the start of his studies. In addition, this prior knowledge would have been available for consideration when concerns emerged in November 2020.

[93] Brennan's father reported that Brennan should not have had financial worries as his father covered all his fees, equipment and expenses, including phone and text books

[94] Student Support | The University of Manchester

Term of Reference 32: *Was any consideration given by the University student mental health, pastoral, or support services to request Brennan's registered GP visit him in his student room to undertake a mental health assessment as requested by his father?*

5.220 The university IMR confirms they do not operate or partner with a GP surgery. At the time of Brennan's attendance there was no GP practice on campus or connected with the university. Information sharing between GP practices and the university about students does not take place except in exceptional circumstances where there is believed to be an immediate risk to the safety of the student or others, and/or with the consent of the student concerned. However, this relies on the university being given the details of the GP with whom the student is registered. Students are not currently required to inform the university of these details; therefore, no record was held as to whom Brennan was registered. Brennan's father did not provide these details and he too may not have known them.

5.221 The university's IMR confirms that the Mental Health Team is staffed by a range of specialities, including a psychiatrist, counsellors, psychotherapists, and mental health practitioners. This means they are qualified to assess risk and provide a level of support and intervention beyond even that provided by a GP. In addition, this team can make direct referrals into a dedicated NHS student mental health service when necessary. Given this, and the fact that no details of Brennan's GP were available, asking Brennan's GP to visit him was not an option. Unfortunately, a qualified practitioner did not make a visit to Brennan to assess him in person, instead a telephone call was made and the mental health nurse, based on their telephone assessment, was of the view that no further support was required at that time. It is noted that this was at the height of the Covid restrictions which were strict in Manchester at that time, but consideration could have been given to a video call to observe his physical presentation, although there is a chance Brennan would not have taken part given his consistent reluctance to accept support.

5.222 The university also pointed out to the Panel that some students do not register with a local GP, preferring instead to remain registered with their home GP which would make a GP visit impossible, and as stated above, GP details are not currently required by the University.

Term of Reference 33: *In view of the Covid 19 related movement restrictions put in place by the University on students, was any special care given to students who were known, or who may be reasonably expected to be known, to be more vulnerable to adverse effects on their mental health by these restrictions?*

5.223 The university IMR reported that very few other universities operated under such a sustained set of local and national restrictions during the 2020/21 academic year, indeed Manchester featured on the national news due to its high rates of Covid infection and the restrictions at the university were noted on the television news. The chronology below relates to the period Brennan was studying [*The links in the chronology below also give examples of some of the communications issued to students around these changes*]:

- **22nd September 2020**: Welcome and induction programme begins for first year students;
- **5th October 2020**: Teaching begins for all students, with in person classes across all three Faculties, save for lectures, which were delivered online;
- **7th October 2020:** UoM and Manchester Met moved to Department for Education Tier 3, in response to local infection rates and discussion with public health officials. As a result, most teaching moved online. Exceptions were on accredited and professional programmes, where on-campus laboratory, clinical and practice-based teaching could be continued, where it was safe to do so);

- **23rd October 2020**: Manchester placed in 'Very High' Tier, with the result that the restrictions on teaching introduced on 7th October remained in place. Restrictions on socialising and travel were also introduced;

- **5th November 2020:** A national lockdown commenced and the arrangements around teaching continued;

- **2nd December 2020**: Manchester moved into national Tier 3 with no change to the restrictions on on-campus teaching;

- **30th December 2020**: Manchester was moved into Tier 4, with no further change on the restrictions on teaching delivery;

5.224 Students who have pre-disclosed support needs are triaged and followed up at the start of each year. This did not happen with Brennan as he had not declared any issue which would lead to support being offered. In addition, all students receive a 'Get Ready Guide' and an online module before the start of the year covering consent/healthy relationships, wellbeing, mental health, and resilience. The module also includes links to sources of support at the end of the wellbeing section. The chair queried whether it was possible to know whether a student had in fact undertaken this module, but was informed that unfortunately, this was not possible primarily because it was too far back in time. Further details about the University's mental health, practical advice and guidance are available in Appendix 3.

5.225 At the start of the academic year all students were sent information about the importance of being aware of the symptoms of Covid, getting tested (although at that point tests were only available in a few City run testing centres) and reporting both symptoms and positive tests to the staff in their halls. When students in halls reported a positive test, they received an email about isolating setting out practical advice about accessing food and support. University records indicate that Brennan and his flatmates were all required to self-isolate between 28/09/2020-12/10/2020 owing to a positive case in their halls and support from the Residences Team was available throughout.

5.226 Part of Covid guidance for students included *"Government advice is that students are strongly encouraged to remain in their current accommodation and not return to their family home or other residential accommodation. If in exceptional circumstances students wish to return home for a period, we will work with them to make sure they can safely leave the campus. We will continue to provide support for students on and off campus".* Manchester was in Tier 3 restrictions from 2 December 2020 due to very high levels of Covid. Clearly, Brennan ignored this as he returned to Norfolk twice sometime at the start of December 2020.

Term of Reference 34: *Did the University observe, or was it reported to any staff, that Brennan's behaviour was causing concern? What action did the university authorities take, and did this trigger any report or alert to the special needs department or to inform his next of kin?*

5.227 As outlined within the chronology and under Term of Reference 31 above, Brennan's flatmates were the first to raise concerns via an email to residential life advisor 2 on 16 November 2020 about his behaviour which they said was scaring them. The flatmates information also included that Brennan had been Sectioned in the past. The IMR reports advisor 2 then contacted residential advisor 1 for assistance in dealing with what was described as a serious welfare issue. The action taken was:

- The advisors provided flatmates with information on who to contact for support or in the event of further issues with Brennan; they promised to escalate the concerns. The advisors escalated the matter reporting their visit to their senior residential life coordinator 3[95] who in turn reviewed the situation with their senior residential life coordinator.
- The following day, 17 November, coordinator 3 attempted to contact Brennan by phone, then visited in person accompanied by residential advisor 4. Brennan was agitated and pacing up and down the corridor; conversation was difficult as Brennan would not engage. He was adamant everything was okay, other than family and financial issues, and he did not have a good relationship with his father. He thought he might have to drop out and return home after lockdown when he could get a flight. Brennan was reminded of sources of support.
- A second visit took place next day, 18 November by coordinator 3 with residential advisor 5. Again, conversation was difficult: Brennan immediately wanted them to leave. His flatmates concerns were raised with him; he was assured they were trying to help him, not punish him. Brennan was dismissive - did not acknowledge any issues, saying he was either too drunk to know what happened or there was no problem in the first place.
- The same day coordinator 3 discussed Brennan with their line manager senior residential coordinator 6. A file note was made to: (1) provide advice and support to his flatmates, and (2) give Brennan the opportunity to show he would not repeat the behaviours which concerned his flatmates and to keep in touch with him,

5.228 There is no record that further probing took place to establish what Brennan's 'family issues' were, or how support with his financial issues might be resolved, for example by exploring access to a hardship fund which may have relieved his worries. The description of Brennan being agitated, pacing up and down, and being difficult to converse with could suggest a level of anxiety which would have benefited from being assessed by one of the Mental Health Team. Without such an assessment there appears, at this stage, to be no justification to contact Brennan's next of kin (see Term of Reference 36). Given Brennan's reports of not having a good relationship with his father it is highly probable that he would not have consented to such contact being made. Brennan's father had also reported in his call that Brennan did not accept or respond to his calls.

5.229 The next part of actions taken will be addressed under the next Term of Reference (35) below.

Term of Reference 35: *What follow up and monitoring of Brennan, if any, was undertaken when Brennan's father raised his concerns?*

5.230 When Brennan's father phoned the university switchboard on 19 November expressing concerns about his son, instead of being put through to student support services, the switchboard emailed the duty officer in the Counselling and Mental Health Service asking that someone contact him, describing him as a 'concerned parent'. This action may have been taken to confirm that Brennan was a student at the university, and to save his father holding on whilst this was done. There is nothing recorded from the phone call to indicate what the concerns were, but it is reasonable to assume from the action taken by the switchboard operator that mental health must have been mentioned.

5.231 The IMR inquires found as there was nothing in the note from the switchboard to suggest that the concerns were mental health related, and because Brennan was not known to the

[95] Residential life coordinators are full time members of staff. The advisor role is voluntary, usually a post graduate student. Within halls of residence all full-time staff members of the team have undergone training in relation to student mental health which also covers suicide prevention and several of them have also completed training in Applied Suicide Intervention. All Residential Life Advisors undertake mental health training with our Counselling & Mental Health Service, and this includes a section around suicidal ideation and suicidal intentions. The Residential Life team also operate an escalation model (24/7) and work very collaboratively with other support services including the Counselling and Mental Health Team.

Counselling and Mental Health Service, the duty officer who read it forwarded the email to the Advice & Response Team[96] (8 minutes after receiving it) asking them to call Brennan's father back in the first instance. As such, the only calls with Brennan's father were with the University switchboard (no notes recorded) and with Advice & Response Team advisor 1 who in the first instance highlighted the case to their manager, the head of the Advice & Response Team, that day. The same afternoon the manager emailed the Residential Life Team to establish whether Brennan was known to them and asked that a discreet welfare check be made. Residential life advisor 3 responded with details and notes of the preceding days interactions, and also discussed the matter that evening in a phone call with the manager of the Advice & Response Team. The notes included the information from Brennan's flatmates that they believed he may have been Sectioned in the past.

5.232 The following day, Friday 20 November 2020, Advice & Response Team advisor 1 phoned Brennan's father who expressed his concerns about Brennan's erratic thinking, impulsivity, and his thin and tired appearance (this raised by Brennan's mother with whom he appears to have had online video conversations and who liaised with his father). Brennan's 2 week period in hospital was noted as being for 'mental health support' and that he should be on medication, but his father did not know what this was, he thought possibly anti-depressants and something to help him sleep[97]. That the hospital admission was under Section was not made explicit and was not clarified with Brennan's father. He told advisor 1 that he did not believe that Brennan was a risk to himself or others, but he asked that the University contact his GP. As already mentioned, the University did not know who Brennan's GP was. Advisor 1's action following the call was to contact the Counselling & Mental Health Service for advice and support in contacting Brennan. This was a sensible action and warranted given the information recorded during this call, however, the circumstances of Brennan's hospital admission should have been probed further.

5.233 The same day as the telephone call with Brennan's father, and advisor 1's contact with the Counselling and Mental Health Service, the duty qualified mental health nurse called Brennan and after a couple of attempts spoke to him. It is simply recorded that he was not keen to engage in a discussion and was clear that he did not want support. Assertive practice would have been good practice at this point.

5.234 The discussion which took place on Monday 23 November between the head of Counselling & Mental Health Services and the head of the Advice & Response Team decided given that this was the first time Brennan had come to the attention of support services the following was agreed:

- As Brennan was not keen to engage with Counselling & Mental Health Services to force him could be counterproductive.
- It was unclear whether a visit to his flat by a member of staff would be helpful.
- To escalate Brennan's case to statutory services if things subsequently escalated.
- Brennan was provided with details of Greater Manchester Mental Health crisis line and situations in which contact was recommended.

5.235 It was good practice by Advice & Response Team advisor 1 to consult their line manager, and then by the head of the Team contacting the Residential Life Team to ascertain whether they had any knowledge of Brennan. The record listing the salient information obtained during the phone call to Brennan's father by advisor 1 is also most helpful (with the caveat that the type of hospital admission was not clarified and recorded as being under

[96] The Advice and Response Team is a proactive team who follow up in instances where students need support that is either complex or which crosses a number of different parts of the University, including where that involves support from specialist services such as the Counselling and Mental Health Team.

[97] Brennan's father reported to the chair that he did not know what medication his son had been prescribed as this was not shared with him, and he was unaware that Brennan had ceased his medication. Brennan had declined permission for the Trust to share information with his father.

Section). Good record keeping is essential; inadequate or inaccurate record keeping can hamper effective information sharing, risk assessment, and decision making. Shortcomings in record keeping is the third most common issue identified in DHRs[98]. Professional curiosity should have extended to probing further Brennan's type of hospital admission and confirming whether it was under Section as reported by Brennan's flatmates when they first raised concerns about him.

5.236 A further gap in information gathering, and a significant one, was that no check was made with Brennan's academic tutor to check on his progress, despite Brennan's father including in his concerns that he thought Brennan had stopped attending classes. Just 3 days after the heads of the two teams discussed what action to take and decided to take a what one might call a 'watching brief' regarding Brennan's behaviour, he had been written to on 23 November 2020 about his absence from tutorials and workshops, and he was behind on his coursework. Had this information been combined with concerns raised by his flatmates and his father, plus his disposition when seen at his flat, a clearer picture and greater concerns could, indeed should, have resulted in a more proactive intervention. This was a significant omission in information gathering. The university IMR suggests this additional information would have been unlikely to change the decision to keep a 'watching brief', but the teams involved have recognised this issue and will be incorporating such checks in future practice. A recommendation has been made concerning this practice and to provide assurance that changes are embedded in university practice.

Recommendation:
Where concerns are raised about a student's behaviour and mental wellbeing, information should be gathered from all relevant pastoral, health support, and academic sources to inform a support plan. This should include the student's tutor who will have an up to date picture of their attendance and progress.

5.237 Whilst liaison between the Residential Life Team and the duty mental health nurse was good, it is disappointing that a qualified mental health practitioner did not visit Brennan in person given the information that he had been hospitalised for 2 weeks (notes record 'last summer', but it was that summer 2020), that he should have been taking medication, and his flatmates had reported Brennan had been Sectioned previously. Brennan's father's information as recorded was not explicit that he had been hospitalised under Section on mental health grounds. Could his father's information recorded during the call that Brennan "*was seeing a counsellor at home but now doesn't have any MH support"* have minimised concerns by mistake[99]? Brennan was actually under the Early Intervention Team for psychosis and had a care coordinator; he was not seeing a counsellor, and the Early Intervention Team had kept his case open in case support was need if he returned to Norfolk. Brennan's father expressed the view that if Brennan had been described as suicidal then a more proactive approach would have been taken; he felt his concerns were not taken seriously.

5.238 Whether a visit in person would have taken place had it been noted that his stay in hospital was under Section is not possible to say, however the notes from the call with Brennan's father did record that he "*was hospitalised last summer 2 weeks (Mental health: imagining things, physically assaulted a neighbour)* and the fact that violence was a factor should have rung alarm bells. The physical description of Brennan from information sources;

[98] Domestic Homicide Reviews Key Findings from Analysis of Domestic Homicide Reviews September 2021 Domestic Homicide Reviews (publishing.service.gov.uk)

[99] Brennan's father advised the chair that the information "was seeing a counsellor at home but now doesn't have any MH support" was based on a phone conversation with Brennan, when he father asked him about whether he was being supported by the Early Intervention Team Care Coordinators in Manchester to his father's surprise he was told that this had stopped. Also he did not know the difference between a 'counsellor' and a 'Care Coordinator' as these job roles had never been properly explained to him.

pacing up and down the corridor, difficult to converse with, erratic thinking, impulsivity, and looking tired and thin, should have resulted in a visit not just to assess his mental and physical wellbeing, but to ensure that lockdown had not negatively affected him and he had accessed food through the process put in place. Difficulties sleeping and loss of appetite are also among the symptoms of depression[100] and this too warranted a check on Brennan in person.

5.239 The chair sought clarity regarding the criteria for welfare checks and learnt that enhanced welfare checks involving a visit in person, are conducted in exceptional circumstances where it is felt that the student is presenting with significant concerns and where they are not engaging sufficiently through a standard appointment process. The heads of the Counselling & Mental Health Service and Advice & Response Team actively considered this option in their review of the case, but discounted it at that stage, in large part because Brennan was aggrieved that he had been contacted. In addition, the Residential Life Team were already in contact with him (and had visited him) and Brennan had expressed to the mental health nurse that he did not want to engage with the Counselling Team.

5.240 The fact that had all information been brought together, including from Brennan's tutor, it is suggested that the decision making would have remained the same i.e., to keep a 'watching brief' on Brennan is very concerning. Whilst cognisant of the impact of Covid 19 and the very limiting restriction in place at the time, a visit to Brennan by the mental health nurse, or at the very least an online interview by them, should have been considered. The combination of factors regarding his past mental health including hospital admission, behaviour in the hall of residence which scared his flatmates, his appearance noted by the coordinator and advisor and reported by his father, plus absence from tutorials and behind in course work, presents a very concerning picture. In the preceding paragraph the criteria given for enhanced welfare checks involving visits in person is a student "*presenting with significant concerns and where they are not engaging sufficiently through a standard appointment process*". It is arguable that Brennan met this requirement; the concerns raised by two separate sources, plus his father, were significant (and would have been more so with his tutor's input), he was also refusing to engage with support offered. This suggests that the threshold for intervention, including for assessing the student in person, is too high and would benefit from recalibrating. A recommendation has been made regarding this.

Recommendation:
The University Counselling and Mental Health Service should examine its threshold for deciding when the enhanced welfare check and assessing a student in person is used and ensure decision making is informed by information from all support services, and academic departments involved in the student's University life, plus external sources who have provided information such as family or guardians if relevant and appropriate.

Term of Reference 36: *Does the university have a policy regarding the circumstances in which information can be shared with a parent or guardian about their adult child's mental wellbeing, and if so under what circumstances can this take place?*

5.241 The University's policy regarding information sharing is based on data protection principles. Students are viewed as individuals; they are legally adults at 18 years of age with rights of self-determination, and there is an expectation that information is held securely and not shared inappropriately. These considerations are balanced against a student's personal circumstances before sharing information with their emergency contact, even if the University is contacted by that emergency contact. Wherever possible staff always try and obtain a student's consent before sharing information about them. The Review has learnt that Brennan refused to give consent for Norfolk Mental Health Services to share

[100] Symptoms - Clinical depression - NHS (www.nhs.uk)

information with his father, therefore given his previous stance and the fact that Brennan said he did not have a good relationship with his father, it is highly unlikely that he would have agreed to the University sharing personal information about him with his father.

5.242 The IMR clarifies that under current data protection legislation, the University is only permitted to share personal information about a student without their consent where it is believed this is necessary to protect their vital (immediate) interests, or those of another person and where it is not possible to obtain their consent. This usually means that the student will have been involved in, or that there is a risk of, an incident or an emergency situation where it is believed they or others may come to serious or lasting harm. A further consideration is the availability of further options to support the student and again, contact with an emergency contact would usually be made only when all other support options had been exhausted.

5.243 The University provided the following examples of circumstances in which information may be shared with an emergency contact or third party, but it is emphasised that each case is considered on its own merits. Examples include but are not limited to:

- Exhibiting behaviour that may pose a serious risk to a student's safety and wellbeing or that of others.
- Attendance or admission to hospital in an emergency.
- A serious physical injury, including significant self-harm.
- Ceasing to engage with studies and staff have been unable to contact the student to confirm their safety and wellbeing.
- Not recently been seen in their accommodation, staff have been unable to contact the student and they are considered missing.
- The student is experiencing a serious mental health crisis.
- A third party has reported significant concerns and we are not able to contact them to establish their safety and wellbeing.

5.244 In Brennan's case the university found the level of concern after assessment by staff, was not sufficient (i.e., was not at a comparable level to the examples above) to consider further contact with his father without Brennan's consent. A further factor was that avenues of potential support e.g., involving the NHS mental health team, had not been exhausted.

5.245 There was no agreement to liaise further with Brennan's father following the phone call with the residential life advisor, and the IMR acknowledges it was not made explicit that follow up was unlikely to take place. However, it would have been reasonable to expect this to have taken place and good practice to do so. Data protection and confidentiality rules rightly precluded personal details about Brennan as an adult being shared with his father without his consent, nevertheless, he could have received a call or email to assure him about the process being undertaken without breaching person information so he knew something was being done. It would be of benefit to include this level of feedback to a parent or guardian who raises concerns within the university's procedures.

Recommendation:
When a family member has raised concerns about a student's wellbeing, notes of the information given by the family member and their concerns should be recorded, placed on the student's file, and a summary of their concerns emailed to the family member to ensure the summary is an accurate representation of the concerns.

Recommendation:
When a family member raises concerns for the health and wellbeing of a student, but it is judged the circumstances do not meet the criteria for sharing personal information, the family member should routinely receive a follow-up phone call or email within 2 working days to summarise the concerns raised and confirm what actions were being taken. There will be very rare cases where this may be judged inappropriate (e.g., if the University is already aware that the student is estranged from their family) in which case this should be recorded.

Recommendation:
Family members contacting the University with concerns about a student should have explained to them the limitations for sharing personal information about the student, when information can be shared, and the duties placed on the University's ability to provide detailed feedback by data protection legislation. The University should consider producing a pdf leaflet explaining their information sharing policy which can be emailed to family members to enable them to digest and understand the policy in their own time.

Term of Reference 37: *Did Brennan come to the attention of University security at any time?*

5.246 At no time did Brennan come to the attention of the University of Manchester security, or local Police.

The Manchester Medical Practice

Term of Reference 38: *Had the GP Practice received Brennan's medical notes from his previous GP, if so when were these received and were they examined to enable the practice to be aware of his mental health history and treatment?*

5.247 After initial difficulties with his GP registration due to missing information by Brennan, he was fully registered on 6 October 2020, and this triggered the request for his previous GP records the following day. There is no record in the IMR that an email was sent to Brennan informing him of his registration being complete. Whether this impacted on the possibility that he might not consult a GP is doubtful, Brennan had not consulted any of the GPs with whom he had been registered previously since leaving school. On the 14 October the practice received a letter from the Early Intervention in Psychosis Team in Norfolk which informed them that the patient had taken his last Risperidone tablet on 1 September 2020, and he had declined referral to the same service in Manchester. He was reported to be stable since his discharge from hospital on 18 June 2020, and the practice was advised to refer him to the local Early Intervention Team if there were future concerns.

5.248 The practice received Brennan's paper GP records on 12 November. The practice notes summariser reviewed and summarised them on 9 December, correctly adding Brennan to the practice Chronic Disease Recall Register due to his previous mental health diagnosis. This would result in Brennan receiving an invitation for a mental health review before 31 March 2021 had he remained in Manchester.

5.249 The practice received no further communication from partner agencies indicating that Brennan required a GP review or for the practice to contribute and share relevant information to inform assessments under the Care Act or Section 42 safeguarding inquires. The final communication received by the practice advised of a psychiatric emergency and his short admission to a hospital in Staffordshire[101].

[101] As Brennan was registered with a Manchester GP at the time of arrest and Section in December 2020, he was at first admitted to a Mental Health hospital with an available bed nearest to the area in which he was registered.

Term of Reference 39: *Bearing in mind the impact of Covid-19 at the relevant time, was consideration given to inviting Brennan to a new patient assessment in light of his previous mental health history or an alternative consultation such as online or phone? If so, what was the outcome?*

5.250 During the period of Brennan's GP registration in Manchester the practice was following Department of Health and Royal College of GPs Covid-19 recommendations to suspend all non-essential work, including new patient medicals. As the letter from the Early Intervention Team stated he was stable and there were no concerns identified which required proactive follow up he was not actively contacted. In due course he would have been invited for review as stated in the previous Term of Reference.

All Agencies involved in Assessing Mental Capacity as part of their duties:

Term of Reference 40: *Are the current procedures, assessment tools, and professionals' training for the assessment of Mental Capacity fit for purpose in assessing the continuum of diminishing levels of capacity from the onset of memory loss and how this affects a person's decision making abilities, through to the onset of clear incapacity to make decisions? If not considered fit for purpose what revisions can be recommended to make the process more effective and helpful for professionals to use in similar cases?*

5.251 The Norfolk and Waveney Clinical Commissioning Group (CCG) provide mental capacity case based training which is included in Safeguarding Adult and Children training for primary care practitioners. Covered within this training are principles of the Mental Capacity Act 2005, assessing capacity, lasting powers of attorney, court of protection and court appointed deputies, in addition to best interest decision. A resource pack is sent to all who enrol on Level 3 training. The CCG hosts monthly meetings specifically for all safeguarding leads and deputy clinicians from GP practices, and also provides specific mental capacity training at 'Protected Time for Learning' sessions for practices. (*This Term of Reference is relevant for services who may undertake assessments as part of their duties).*

5.252 The CCG has recently (2022) commissioned a one day live and interactive online Mental Capacity Act training course which will be free of charge to healthcare professionals in the region. The course consists of 8 sessions; one every 2 months). The training covers how to:

- Apply the principles of the Act to clinical practice.
- Make and document a mental capacity assessment.
- Reach balanced and informed best interests decisions.
- Implement best interests decisions.
- Assess the validity and applicability of advance decisions.
- Work with Donees (welfare attorneys) and court appointed deputies refer to the Office of the Public Guardian when appropriate.
- Involve an Independent Mental Capacity Advocate (IMCA) when required.

5.253 It is the view of the Mental Health Trust that their current procedures, assessment tools and training for the assessment of mental capacity are fit for purpose.

5.254 Adult Social Care assess their Mental Capacity Act training and procedures as both being fit for purpose. Their IMR comments that decision making concerning Sofia's capacity was sound, nevertheless in hindsight this decision could have been strengthened by a telephone conversation with Sofia herself. However, there was considered to be no reason to doubt the information provided by Sofia's youngest son that she appeared to have capacity given that he had made the safeguarding concern. It is welcome that on reflection the view is that Sofia should have been spoken to directly. Sofia's youngest son is not a

trained practitioner in assessing mental capacity, and he did not see his mother in person, he spoke to her on the phone, reinforcing the view that Sofia should have been spoken to by a trained practitioner with experience of mental capacity assessments. Backing this up with the views of a practitioner such as Sofia's GP who knew her personally would also have provided reassurance that the assessment was as accurate as possible. A home visit by a practice nurse or other health professional involved in Sofia's routine treatment and reviews could also have been considered. Covid was not an issue at the time of the safeguarding concerns.

5.255 The Approved Mental Health Professional (AMHP) demonstrated their ability to act on their training to assess Brennan as lacking in capacity due to being mentally unwell and in need of hospital admission. A Mental Capacity Act assessment paperwork is on file supporting this.

5.256 The Mental Health Trust provides mandatory e-learning for all staff on the Mental Capacity Act and Mental Health Act, both cover the assessment of decision specific capacity, and policies cover both Acts which includes assessment, record keeping and action i.e., best interest decisions. The quality, accuracy and prevalence of capacity assessments is monitored via the Trust Mental Health Forum and audited by inhouse and external auditors. The IMR suggests an improvement to training would be to include scenario-based learning, debriefing, and After Action Reviews of incidents and near misses linked to capacity assessments as outlined in the NHSEI Patient Safety Incident Framework 2021.

Fire & Rescue Service:

Term of Reference 41: *Had the Fire & Rescue Service provided any fire prevention advice to the victim or family members regarding any safety measures for Sofia's home?*

5.257 The Fire Service checked their records and confirmed to the Panel that the service had not received any referral or contact for advice on fire prevention or safety measures for Sofia's address.

Term of Reference 42: *From the investigation into the causes of the fire address the following:*

a) *was the electronic Nest surveillance and alert system for the fire alarm active at the time of the fire? If not, why not?*

5.258 The Fire Service investigation found a 'Nest' smart communications system was set up in Sofia's home which contained a smoke detector, a carbon monoxide detector, and a CCTV camera. These were linked to her eldest son Brennan's father's Smart phone. The investigation identified these devices were active and working effectively at the time of the fire.

b) why did smoke detectors and/or fire alarm measures not alert anyone to the presence of the fire?

5.259 The investigation confirmed that an alert message was sent to the Smart phone to which it was linked at 04:50hrs showing the smoke detector and carbon monoxide detector had been activated. However, prior to the start of the fire that night, Sofia's eldest son had left the property where he was usually living as her carer and returned to his own property. He reported taking this step as he was fearful of his son Brennan following their altercation that night as described in the Chronology of this Review. Brennan remained in the house alone with Sofia who was upstairs in bed. It is not known whether Brennan was aware that his father was not in the house, he has declined to take part in this Review; he also refused to discuss the incident when under Section in the secure unit. On leaving the property

Brennan's father had switched off his phone, hence he was unaware of the alert sent following the activation of the smoke and carbon monoxide alarms until later that morning. This was a very serious omission given that Brennan's father had not linked any other family members to the devices as back up. Had this been done another person could have called the emergency services.

Recommendation:
That statutory regulations governing Smoke and Cabon Monoxide Alarms be amended to include the requirement that all internet enabled alarms must be linked to a minimum of 2 persons devices to ensure alerts can be picked up and acted upon at all times. Manufacturers must ensure the system cannot become operational until this is done, and if a device has to be deleted at any time another must be installed simultaneously to enable the system to continue to function continuously with the provision of 2 separate individuals to receive alerts.

5.260 The investigation into the fire showed the Fire Service received a call from a member of the public to the premises at 06:41hrs, this was 1hr 51mins after the alarm alert was sent to the Smart phone to which the devices were linked. A considerable time after the first activation of the alarms which enabled the fire to take hold.

Term of Reference 43: *Were there measures which could have prevented the damaging and fatal effects of the fire which were not present in the property?*

5.261 As is clear there were alarms in Sofia's home intended to prevent the damaging and fatal effects of a fire. However, these were limited in their effectiveness, and the Panel believe there were additional steps which could have prevented such devasting results.

5.262 The Panel members expressed their surprise and concern that the alarms were only linked to one Smart phone; there was no second back-up connecting the alarms to another family member's device or a suitable call centre. Of additional relevance is Sofia's eldest son occasionally needed to travel abroad where internet connectivity can be variable, or impossible during a long flight. There could also be occasions when a phone has no power. Thus, a second linked device should be considered absolutely essential back-up to ensure an alarm alert is not missed.

5.263 The importance of having robust links for safety devices such as smoke alarms has recently been highlighted in a Coroner's Regulation 28 Report to Prevent Future Deaths[102] of October 2022, This report arose from the death a frail elderly man where a fire started in the mechanical motor of his bed mechanism. His smoke alarms were not connected to a telecare call system and there were crucial delays in calling out the Fire Service. Had the smoke alarms been connected the call would have been answered by the linked call centre as a matter of priority, instead several vital minutes were lost seeking confirmation from a neighbour that a smoke alarm was going off in the victim's flat.

5.264 In addition to the Norfolk Fire Service safety assessment and advice service, Norfolk County Council provides advice and a range of assistive technology equipment ranging from alerts of falls to smoke detectors which are linked to a back-up telecare call system.

Recommendation:
All services involved in providing care and/or advice to vulnerable adults should include in their home safety advice the promotion of the County Council's assistive technology equipment which includes the services of the telephone call centre back-up for emergencies when a family member or carer cannot be contacted. This information must always be included where a pendant alarm is recommended or provided. This practice should become routine by September 2023.

[102] Reginald Cauthery - Prevention of future deaths report - 2022-0326 (judiciary.uk) accessed 18.11.22.

Thus, in the event of carers or family members not being available to pick up an alert call, alerts are transferred to the telecare call system. Had this equipment been used the Fire Service would automatically have been called by the system and the fire tackled much earlier (see Appendix 4 for links on assistive technology). There was a missed opportunity to promote this service at the time Sofia was recommended a pendent alarm and when this was arranged. A recommendation has been made to promote this equipment.

5.265 Since the tragic incident which led to this Review, Norfolk Fire & Rescue Service have started a programme of training to help domiciliary care providing agency staff to identify fire risks as part of their practice and to make referrals to the Fire Service. This training is available to all domiciliary care providers. The aim is to increase the routes into the Fire Services' expert safety advice, to ensure residents have access to the most effective safety equipment, and which is appropriately linked to the telecare system in addition to relatives.

5.266 The Fire & Rescue Service representative on the Panel arranged an online meeting between himself, the chair, and the National Fire Chief's Council lead on 16 December 2022. The practicality of a national recommendation which could be implemented to improve the safe operation of commercially available wi-fi enabled products such as that fitted in Sofia's home was discussed. Review recommendations are expected to be achievable, realistic, and capable of being implemented, but the meeting reluctantly acknowledged the challenge of achieving change nationally across commercial international businesses was neither realistic, nor achievable via a DHR for which the Community Safety Partnership has overall management. As an alternative the National Fire Chief's Council lead agreed to discuss the issue at his next national meeting. This took place in February 2023 where other lead officers nationally were made aware of the limitations of these products, and the need to stress the importance of having at least two devices linked to the system. This is essential to prevent fire alarm alerts being missed should a linked device not be available or switched on if future deaths are to be prevented.

5.267 An email has been sent to ROSPA to ask that the issue of 2 devices being linked to a wi-fi linked fire alarm system can be publicised.

5.268 At the time of writing, it is understood that a Coroner's Inquest is to take place in due course into Sofia's death, and the matter of commercially produced wi-fi enabled home safety devices having links to more than one person's mobile phone may be an issue the Coroner may wish to examine.

5.269 The Review makes recommendations to raise awareness with members of the public and agency practitioners concerning the issues identified in this Review with regard to the installation of privately purchased wi-fi enabled home safety devices such as smoke and carbon monoxide detectors.

Recommendation:
Websites including the Norfolk County Council assisted technology site, the Fire & Rescue Service home safety site, and other county websites which give home safety advice, to insert a prominently displayed message, strongly advising that at least two people's phones, tablets or similar devices should be linked to wi-fi enabled smoke and carbon monoxide alarms to ensure fire alerts can always be received and acted upon immediately. Changes to websites should be in place by September 2023.

Recommendation:
All statutory, voluntary, or private services' practitioners and carers whose role includes home safety advice and where a service user has or are intending to install privately purchased wi-fi enabled fire alarms, should strongly advise that at least two devices should be linked to the alarms to ensure back-up if one device is unavailable to enable action to be taken immediately an alert is received. Giving this advice should be included in all relevant training for practitioners and carers. This recommendation's message should be circulated and acted upon by June 2023 and included in training by September 2023.

6. Conclusions

6.1 From what we have learnt of Sofia during this Review she was an independently minded, intelligent woman, who, despite having retired from academia, believed in the importance of education, and still held strong didactic instincts to impart knowledge. This is demonstrated not just by her own remarkable life achievements, the achievements of her family and her own academic career, but by her teaching the manager of a care agency Swedish phrases during his visits. She remained a great reader and intellectually curious. Her family was very important to her, and she appears to have been saddened by the rifts in her adult children's relationships.

6.2 Information obtained for the Review suggests a difficult balancing act for both practitioners and the family between Sofia's expressed wishes and those of her naturally concerned adult children who wanted the best for her, and for her to be safe. They respected her most ardent wish to remain in her own home and did their best to achieve this. However, there were shortcomings in practice in that Sofia was not consulted in person independently by professionals to establish her true wishes, especially as far as having her grandson Brennan in her home was concerned.

6.3 Following her fall in 2019 Sofia appears to have reached a stage of acceptance regarding her mobility although it did improve in the months following her accident and she regained her confidence; her improved mobility appears to have been good for her age. She appears to have reached a degree of contentment as she disclosed to her community assistant practitioner that she loved lying on her bed looking out the window at the magnolia tree she had planted 50 years ago, and this was where she said she was most comfortable, happy, and contented. Sofia enjoyed sitting under this tree reading her books. It must have been a significant adjustment for Sofia who had previously lived peacefully and independently on her own, to have Brennan in her home when he was there. Not only were they generations apart in age, experiences, and culture, but Brennan's behaviour and use of illicit drugs appear to have caused Sofia distress and anxiety, and she was said to be scared of him in one assessment. The distant relationship between Brennan and his father complicated matters and communication between them was problematic at best or absent. Brennan refused to consent to his father being given information about him. Opportunities for guiding more positive behaviour by Brennan were impeded by their lack of familiarity with each other and Brennan's physical and emotional distance from his father.

6.4 Professionals involved in monitoring Brennan's mental health following his discharge from hospital in 2020 did not recognise Sofia as the owner of the home to which he was discharged, nor were her views sought. The fact that a few weeks after his return from hospital Brennan was told to leave by Sofia because he was smoking (recorded by Police as Brennan smoking 'weed' in records of the call reporting him missing by father), confirms her unhappiness with his presence in her home. This makes it especially sad that Sofia's previously quiet later years were so disrupted; she should have been consulted. It was as if this intelligent, dignified, elderly woman was invisible. Older people must not be

overlooked and ignored; any tendencies towards inequality of treatment and ageism needs to be resisted and challenged at all times.

7. Lessons to be Learnt:

Hearing the Voice of Older Adults

7.1 Whether it was ascertaining Sofia's views regarding her freedom to make autonomous decisions about her life and her care, or having the opportunity to express whether she agreed with Brennan returning to live in her home after discharge from hospital, Sofia's own voice was not heard directly or sought. She was the legal owner of her own home, but she was not given the respect and dignity of making these fundamental decisions herself. She was invisible to services, especially when the decision was made to return Brennan to her home despite an assessment recording that she was scared of him. Her voice was also not heard by the local authority Housing Department about Brennan returning, instead Brennan's father's report that Sofia was willing to have him return was accepted.

7.2 Sofia's GP was aware that she had designated Lasting Power of Attorney to her daughter and her friend and neighbour who was also her solicitor, and financial matters were managed by one of her younger sons, but none of the other services were aware nor did they enquire to see if this was the case. Whilst it is recognised that Sofia was deemed to have mental capacity therefore neither of her LPAs would be required to decide on her behalf, it would have been justified to enquire if she had an LPA in case they needed to be consulted at some point.

7.3 Whilst not all older or vulnerable people will have a Lasting Power of Attorney in place, it would be appropriate for policies and procedures to prompt practitioners to enquire whether this is the case and to record this information.

7.4 Care Act Guidance 2014 states: *"Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances."*

Much more should have been done to have regard to and for Sofia's views, wishes, feelings and beliefs when deciding on actions, particularly in regard to Brennan living in her home. Older family members must not be ignored in assessments and when making decisions.

Think Family

7.5 The Think Family approach recognises and promotes the importance of a whole-family approach[103] which includes the concepts:

- 'No wrong door' – contact with any service offers an open door into a system of joined-up support.
- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities.
- Providing support tailored to need – working with families to agree a package of support best suited to their particular situation.

[103] Think child, think parent, think family: Introduction - Think Family as a concept, and its implications for practice (scie.org.uk)

- Building on family strengths – practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities. For example, family group conferencing is used to empower a family to negotiate their own solution to a problem.

Think Family does not replace individual support but is intended to work alongside it. The holistic nature of the model enables assessments to consider the environment, family, cultural and social systems within which individuals live (e.g., housing, finance, employment, relationships).

7.6 Although primarily used in work with adults who have dependent children, Think Family is valid in all family situations including where a family member has care and support needs. Had this approach been used, Brennan's home circumstances would have been given more importance, and as a consequence Sofia would not have been invisible to the services involved with him. There were rare glimpses of Sofia in records but usually via communication with her eldest son, Brennan's father, never with Sofia herself. A Think Family holistic method of working would and should guard against such omissions.

7.7 There is a need for a cultural change within all adult focussed services for the 'Think Family' approach to be successfully embedded in everyday practice, and this needs to be promoted at all structural levels of services in addition to being reflected in policies and procedures.

Professional Curiosity:

7.8 Unfortunately, a lack of enhanced professional curiosity is a common finding in DHRs, along with concerns about the degree to which professionals were supervised to foster a culture of professional curiosity[104]. Basically, this means either the right questions have not been asked, open questions have not been used to obtain full and meaningful answers, or not enough depth and breadth of enquiry has been undertaken. Coupled with the need to 'Think Family', there was a lack of professional curiosity and probing to fully establish the context and meaning of what was said or reported, and to triangulate information from a variety of sources to establish accuracy and clarity. Had the two approaches been combined, Sofia, as a senior and key member of the family system, would not have been missed from assessments and decision making. The fact that Sofia was not spoken to directly by services was a serious failing and showed a significant level of lack of professional curiosity.

7.9 A lack of professional curiosity meant that cancelled or missed health related GP appointments for Sofia were not followed up. This may appear to be a minor issue, but missing a number of appointments where a patient needs assistance to attend may be either a sign of a person being isolated or their health and wellbeing being neglected.

7.10 Key information given by Brennan and his father which should have been further clarified and examples of behaviour being sought were lacking. This meant statements or attitudes were not defined when taking information for assessments, for example what exactly happened to cause Sofia to be scared of Brennan? What was meant when Brennan was said to be 'concerned' about his grandmother; what was he concerned about? When Brennan's father reported that Brennan had a strained relationship with Sofia and he had a phobia about her, what did this actually mean? Why was it strained and how did the phobia manifest itself?

---

[104] Bracewell K, et al (2021) "*Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide*" Journal of Gender-Based Violence • vol XX • no XX • 1–16 •. Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide in: Journal of Gender-Based Violence Volume 6 Issue 3 (2022) (bristoluniversitypressdigital.com)

7.11 Had professional curiosity practices operated in information gathering fewer gaps would have been evident, and a greater understanding of the family system and relationships could have been achieved. Norfolk Safeguarding Adults Board April (2021) Domestic Abuse and Older Adults (Issue 01)[105] states the importance of professional curiosity and stresses:

> *"… the need to be alert to the signs of possible domestic abuse, and to follow up on concerns by asking questions and trying to see the person alone. It is important to work in partnership with other agencies in domestic abuse cases and link with specialist services. It is also essential to share information where you are concerned that a person is at risk of serious harm"* (p2).

7.12 However, there was no sharing of information between agencies, either due to patient/service user confidentiality or the safeguarding policy requiring an individual's consent if they were deemed to have mental capacity. These criteria overrode the stated importance of working in partnership with other agencies to share information, avoiding silo working; this in effect hampered the gathering of information to triangulate what was known and to determine any level of risk.

Recognition of Domestic Abuse and Risk Assessment:

7.13 The recognition of domestic abuse in the adult family violence and abuse context was absent. Whilst improvements have taken place with respect to intimate partner domestic abuse, recognition of abuse within the wider family sphere is lacking and this is even more pronounced when older members of the community are involved. Yet those with additional needs and frailties can be just as vulnerable as children, and equally unable to escape their abuse easily. Tragically this was the case for Sofia who was unable to escape the fire.

7.14 Norfolk's Safeguarding Adults Board[106] highlights "domestic abuse is considered more hidden in this age group and is complicated by often having a range of care needs and wider relationship issues. Prevention is dependent on recognition and early intervention" (p2), This message must filter down through all organisational levels and into practice.

7.15 There is a need to identify when a safeguarding concern meets the definition of domestic abuse and when this occurs during the information gathering and assessment process, reach for a DASH risk checklist specific to domestic abuse. Whilst DASH has its flaws for use in adult family abuse cases, it is gradually being adapted for older people therefore more tailored options are becoming available. In addition to training practitioners, the Care Act and the safeguarding system needs to be adapted to support practitioners to gain safe and direct access to those for whom concerns have been raised, to risk assess effectively, and deliver a coordinated multi-agency community response to familial domestic abuse which it is acknowledged can be complex to work with, and in which older victims in particular can face multi-layered barriers to accessing and accepting help.

7.16 Brennan was initially diagnosed with 'transient psychosis with mental health secondary to the use of cannabinoids', therefore his use of cannabis was recognised as a contributory factor to his mental illness. By his own admission Brennan's use of cannabis started in his early teens which research shows is a risk factor for mental ill-health, notably psychosis. As discussed in this Review mental ill-health and substance misuse are well recognised in research as being additional high risk factors, and even more so in familial abuse. Sadly, in this case because Brennan did not admit in assessments to harbouring thoughts of harming his family, none of these heighten risk factors were considered. Harm to family

[105] Domestic-abuse-older-adults.pdf (norfolksafeguardingadultsboard.info)
[106] ibid

members should always be factored into risk assessments in such cases and reviewed regularly.

7.17 As Pearson & Berry observe "The association between cannabis use and psychosis is important for all stakeholders to understand. Cannabis users, potential future users, existing schizophrenia patients, families of at-risk persons, researchers, clinicians, and policy-makers all need to be aware of the multi-modal and complex relationship cannabis use has to a variety of psychotic outcomes in order for harm to be reduced and appropriate informed consent be achieved."[107] It is therefore important that all services and practitioners take this association between cannabis and psychosis into account in assessments, especially where a service user shows ambivalence or resistance to treatment and accepting of support, The addition of other substances such as alcohol misuse will also heighten risk. Risk to others as well as to self needs to be subjected to thorough and dynamic assessment and changes in risk recorded. Where family members are involved in supporting a service user the risk assessment should include consideration of risk from domestic abuse.

Communication with Family:

7.18 Whilst services rightly try to empower those who use their services it is important to remember that a majority of the public may rarely need to contact services or use them. When they do contact a public service be that Social Care, Health, or Mental Health Services, it will inevitably be an unfamiliar process. If this contact takes place at a time of concern or distress then the alien nature of the process can be amplified. Good communication skills are required, and there needs to be clarity about the service provided and any limitations which families may need to be unaware of.

7.19 Sofia was not given the opportunity to speak directly to Adult Social Care regarding the safeguarding concern therefore no opportunity was given to communicate to her any services available which could have allayed her fears of being taken into residential care and which could support her to remain in her much loved home. Of particular note no information about a carer's assessments was given. This could have been communicated in a positive way and in acknowledgement that caring can sometimes be stressful and tiring, and relief may have been required from time to time by her eldest son in addition to the stress he was under due to Brennan's mental ill-health.

7.20 There appeared to be occasions when Brennan's father thought he was imparting the necessary information or was expressing his fears or concerns about Brennan's actions, but these were misunderstood or understood differently by practitioners. For example, although the Police understood that he was fearful of his son; he did not communicate any actions by Brennan that were a crime, and the shortcomings in communicating with Brennan meant they did not detect mental distress sufficient to remove him.

7.21 This again brings us to the techniques of information gathering, professional curiosity, and the need to reflect back what a person is saying to establish that meaning has been understood. Importantly, all professionals need to recognise the impact of fear and anxiety and how this affects communication. It was noted that the Police call taker had difficulty obtaining information from Brennan's father during his 999 call and during the Police attendance he appeared agitated verbally and physically. Putting thoughts into words, and increased speed of speech are recognised symptoms of anxiety, which can affect the ability to communicate effectively. This can result in forgetting words, the incorrect use of words, and long pauses between words. When under duress instead of speech being clear and natural, thoughts are racing or overthinking takes place and the opposite to clarity

[107] Pearson, N.T. and Berry, J.H., 2019. Cannabis and Psychosis Through the Lens of DSM-5. *International Journal of Environmental Research and Public Health*, [online] 16(21), p.4149. https://doi.org/10.3390/ijerph16214149

can be the outcome.[108] The effects of trauma can also result in a person having difficulty not only expressing themselves but listening and comprehending what is being said to them, thus explaining why many in an anxious state have trouble absorbing information which can make having longer and intellectual conversations a challenge.[109]

7.22 Whether Brennan's father fully understood the nature of his son's mental ill-health and the implication of his diagnosis is unclear. Although psychiatrists and mental health staff involved him and explained their plans for Brennan and the team were very good at being accessible on the phone, the information he gave to the university appears to show a lack of full understanding, for example the purpose of the medication Brennan was prescribed, and that he had a counsellor rather than a mental health care coordinator. The different practitioner roles were not understood by him and Brennan had denied information sharing with his father. He did not have a copy of a contingency plan, and there is no record that he was given written information regarding how to manage Brennan's behaviour. Communication with family or carers needs to be in a variety of forms: taking in what is said can be variable when someone is under duress. When so much information is online there can be an expectation that family or carers simply go online to find what they need, but for some being given written information may be preferred particularly at times of stress, and to which they can refer as needed.

7.23 Overall, it would appear that whether it was Brennan's father in contact with the university, Mental Health Services and the Police, or Sofia's younger adult children's concerns raised with Adult Social Care, the family did not feel listened to.

Assistive Technology

7.24 The Review has highlighted the pitfalls of modern technology if thought and care is not given to its use. There are huge benefits to be gained from modern assistive technology to enhance home safety both for people and the home environment. Sadly, the implementation of the commercially purchased product for Sofia's home was inadequate as the device was only linked to one Smart phone.

7.25 The availability of the county council's own assistive technology was not shared with the family when Sofia was receiving reablement services. The variety of this useful equipment, and the fact that it is backed up by a call centre facility must be promoted, as many people may be unaware that this is available through the local authority. Websites such as Fire & Rescue and others providing home safety advice also need to highlight to the public the pitfalls identified in this Review when privately purchasing wi-fi enabled home safety equipment such as smoke detectors. The importance of linking alarms to a minimum of two devices to maintain safety must be emphasised.

Early Learning:

7.26 The dangers associated with having a single linked device to a wi-fi enabled home safety device which includes smoke detectors or similar alarms was identified early in the Review process. As a consequence, gaps in public information on the Fire & Rescue Service website and the County Council's assisted technology website were recognised and steps taken to increase the information available to highlight the essential safety step of having

[108] Can Anxiety Cause Problems with Speech? 04/11/2022 in Voice Therapy /by Great Speech
Can Anxiety Cause Problems with Speech? - Jumbled, Slurred (greatspeech.com)
[109] "How Trauma Can Affect Communication" 28 January 2021. How Trauma Can Affect Communication — Sana Counselling

a minimum of two devices linked to receive alerts when an alarm has been activated. The Fire & Rescue Service website[110] was update with this advice on 29 September 2023.

7.27 The Mental Health Trust acted upon the recommendation regarding contingency plans being shared with involved services and related parties/carers. Compliance was audited and plans found to be present in 92% of cases. The action was completed in December 2021. A recommendation remains to ensure the focus on this work continues.

7.28 During the review of agency training it became clear there was no overall county level knowledge of the disparate and varied domestic abuse training taking place across the county. Therefore, in the autumn of 2022 a Domestic Abuse & Sexual Violence Board training group was formed with the aim of reviewing all domestic abuse training taking place, assessing the content, ensuring courses were up to date with legislation, and to achieve quality and consistency of content whilst allowing for specific services professionals' needs. A survey of commissioners of training took place which was completed by February 2023. An audit of training found numerous high quality training packages and high satisfaction among professionals, although some gaps in content were identified and a task and finish group determined Community Safety Partnership owned Domestic Abuse Training Standards were required to enable gaps to be filled. In September 2023, a draft set of Domestic Abuse Training Standards were presented to the Norfolk Domestic Abuse and Sexual Violence Group, which were approved in principle. A method of implementation is underway. A recommendation regarding training remains to ensure continued governance of the process.

7.29 An internal inquiry by the Police identified that officers interviewing Brennan had asked closed questions which resulted in limited information being obtained. The officers concerned have had this raised with them formally by an inspector and instructed that they must ask open questions and thoroughly investigate the circumstances at incidents. We frequently learn more from our mistakes, and it is hoped that lessons from this Review will inform all those involved in assessments, and their training and procedures will reinforce this learning.

7.30 Although not very early in the review process, the actions recommended for the GP Practice/Integrated Care Board were completed in May and June 2023. The recommendations remain listed for transparency and action plans were provided.

8. Recommendations:

8.1 DHR Statutory Guidance (p38) states: Recommendations should include, but not be limited to, those made in Individual Management Reviews and can include recommendations for national level bodies or organisations. Recommendations should be focused and specific, and capable of being implemented. The following recommendations arise from Panel deliberations, and agency IMRs. Family members have also contributed. Timescales will appear in the action plans.

Review Panel National Recommendations:

1. Independent Office for Police Conduct Recommendation:

To avoid delays in the completion of a Domestic Homicide Review where an IOPC inquiry is taking place concurrently, the IOPC concluding report should be expedited promptly, and made available to the DHR Panel within 6 months of the verdict concluding the criminal trial to enable all relevant information to be included in the Review. Where the IOPC cannot conclude its report within this time it should write to the relevant DHR chair and Community Safety Partnership chair with a full explanation of the delays and a deadline for completion.

[110] Smoke alarms - Norfolk County Council

2. NHS England Recommendation:
That NHS England examine the efficacy of mandatory dedicated domestic abuse training for all GPs as part of their continuing professional development to enable them to keep up to date with all aspects of domestic abuse and the support services available in their area. If possible, training time should be protected to enable GPs to attend.

3. National Institute for Clinical Excellence (NICE) Recommendation:
NICE guidelines on hospital discharge should be revised to include ensuring consideration of vulnerable persons residing in the accommodation to which the patient/service user is returning; specifically in respect of any risks to others the patient/service user may pose to other occupants. The policy must outline the need to undertake and document assessment of risk or abuse; whether information should be shared with other residents or carers to maintain safety; whether a referral to the local safeguarding team/lead or MASH team should be considered, and if a referral to MAPPA or MARAC is needed, or consideration of a Potentially Dangerous Person (PDP) referral to local police.

4. Department of Health & Social Care Draft Recommendation:
The Department of Health & Social Care should consider a public health awareness raising campaign for secondary school aged children and young people with the aim of highlighting the negative impact on mental health of early and frequent cannabis use.

5. Department of Health & Social Care, Home Office, and Domestic Abuse Commissioner for England & Wales Recommendation:
That the Department of Health & Social Care, Home Office and in collaboration with the Domestic Abuse Commissioner for England & Wales commission urgent research 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. The results of the research should be used to inform the review being undertaken by DHSC to strengthen and clarify the Care Act 2014 guidance.

6. Department for Levelling Up, Housing & Communities Recommendation:
That statutory regulations governing Smoke and Cabon Monoxide Alarms be amended to include the requirement that all internet enabled alarms must be linked to a minimum of 2 devices to ensure alerts can be acted upon at all times. Manufacturers must ensure the system cannot become operational until this is done, and if a device has to be deleted at any time another must be installed simultaneously to enable the system to function continuously with the provision of a minimum of 2 separate individuals to receive alerts.

Review Panel Local Recommendation:

Multi-Agency

Recommendation 1: Domestic abuse training which includes intimate partner abuse and adult family abuse across the whole age range, and includes the impact on children, should be of a consistent content and standard, and mandatory for all public facing staff in the following services.***** Professional curiosity should be at the core of all training and, as is expected when children are present at the scene of a domestic abuse incident, training should include the need to check on the wellbeing of vulnerable adults present in the household.

1. Norfolk County Council services (provided or commissioned) involved in welfare, caring services, and safeguarding.
2. Community Health Care Services

3. Secondary Healthcare Service
4. Voluntary sector services commissioned by the local authority and CCG i.e., those supporting older people, carers, those living with addiction and/or mental ill-health including dementia/Alzheimer's disease.
5. Housing officers (District Council and Housing Associations)

A significant amount of current training is CPD accredited. This should be maintained and any new training programme should aim to be CPD accredited where appropriate to enable staff to evidence their continuing professional development. The Community Safety Partnership Board will be responsible for the governance of this recommendation.

***** It is recognised that Police and Probation have national level approved training with which they have to comply, and GP practices work within their NHS contract obligations therefore this training cannot be mandated. However, we are sure they would be welcome to attend county multi-agency domestic abuse training if resources allow.

Recommendation 2: All services should reinforce within their policies and procedures, and in staff supervision, the importance of professional curiosity, what this entails in practice, and:

(a) Practitioners and their managers should be reminded of the steps to take as described in Safeguarding training with the aim of achieving the fullest, corroborated information for assessments as possible.
(b) Anyone expressing concern for another person during an assessment or interview should be asked for examples and to describe those concerns, and this must be recorded in detail.
(c) If a vulnerable person who requires assistance to attend appointments misses two or more appointments active enquiries should be made directly with that person to establish the reason and to ensure their wellbeing.
(d) Enquiring whether an adult for whom a referral is made has a Lasting Power of Attorney should be routine, written into procedures, and details recorded to ensue where relevant they are consulted.

Recommendation 3: All services undertaking assessments should take a 'Think Family' approach and:

(a) Use their full assessment skills and professional curiosity to ensure information for assessments, care plans and risk assessments is fully inclusive of all family members /family structure, plus any carers, and where relevant note who is the home owner or holder of a tenancy.
(b) To ensure a 'Think Family' approach is embedded in organisational and cultural change at all levels, directors of services should ensure policies, training, and procedures promote this approach, clearly set out practice expectations, and audit this change in practice on a 6 monthly and then an annual basis.

Recommendation 4: All local health inpatient and residential social care providers: To review, and revise where necessary, the providers Discharge Policy to ensure it covers consideration of vulnerable persons residing in the accommodation to which the patient/service user is returning; specifically in respect of any risks to others the returning patient/service user may pose to other occupants. The policy must outline the need to undertake and document:

(a) Assessment of risk criteria (risk of harm or abuse)
(b) Actions including whether or not information should be shared with other residents, or carers to maintain safety and/or a referral to the local provider safeguarding team/lead or MASH team.
(c) Also, to consider if a referral to MAPPA or MARAC is needed, or consideration of a Potentially Dangerous Person (PDP) referral to local police.

Assurance of this action must be provided:
For Health providers – the ICB Adult Safeguarding Lead/team
For Socials Care providers – the local authority Head of Integrated Quality Service/team.

Recommendation 5: To reduce risk in adult family abuse cases it is strongly recommended that a task group is set up to investigate the use of a risk assessment tool by services when a safeguarding concern involves an allegation or risk of abuse within the family context which therefore meets the definition of domestic abuse. Where the safeguarding concern is about an older adult a suitably adjusted DASH risk assessment designed for older victims could be considered for use e.g. The All Wales Risk Identification Checklist (RIC) for MARAC Agencies or Cambridgeshire & Peterborough MARAC Referral Form and Risk Indicator Checklist for Older People (over 60).

Recommendation 6: When services become aware during assessments that a person has habitually used cannabis from their early teens and they develop early onset psychosis symptoms, this should be factored into risk assessments. This is essential in cases of poly-substance misuse co-morbidity to ensure assessments are robust in assessing risk to others as well as risk to self.

Recommendation 7: All services providing care and/or home safety advice to vulnerable adults should include the promotion of the County Council's assistive technology equipment which includes telephone call centre back-up for emergencies when a family member or carer cannot be contacted. This information must always be included where a pendant alarm is recommended or provided. This practice should become routine by September 2023.

Recommendation 8: Websites including the Norfolk County Council assisted technology site, the Fire & Rescue Service home safety site, and other county websites which give home safety advice, to insert a prominently displayed message, strongly advising that at least two people's phones, tablets or similar devices should be linked to wi-fi enabled smoke and carbon monoxide alarms to ensure fire alerts can always be received and acted upon immediately. Changes to websites should be in place by September 2023.

Recommendation 9: All statutory, voluntary, or private services' practitioners and carers whose role includes home safety advice and where a service user has or are intending to install privately purchased wi-fi enabled fire alarms, should strongly advise that at least two devices should be linked to the alarms to ensure back-up if one device is unavailable to enable action to be taken immediately an alert is received. Giving this advice should be included in all relevant training for practitioners and carers. This recommendation's message should be circulated and acted upon and included in training as soon as possible.

Adult Social Care

Recommendation 10: To ensure reported improvements in offering carer's assessments described to the DHR Panel is maintained, an annual audit of carer assessments offered, carer assessments taken up, and outcome of the support provided should be undertaken and reported annually to the director for Adult Social Care and the Adult Safeguarding Board.

Recommendation 11: That the Approved Mental Health Professional report (AMHP) template be updated to improve visibility and clarity of the risk assessment section with the aim of making this vital information plainly visible to clinicians throughout the patient's journey in Mental Health Services both hospital and community based.

Mental Health Trust

Recommendation 12: Mental Health Service contingency plans should take a 'Think Family' approach and be shared with related parties/carers having been written in plain English and avoiding professional jargon to ensure it is accessible to enable families and/or carers to fully understand the steps to take when required. This should include relevant contacts and phone numbers, and guidance on information required when reporting serious concerns.

Recommendation 13: The Early Intervention Team should confirm back after any meetings with the next of kin in a quick memo (email or letter) any agreed actions/key information discussed by both sides. This could be a simple copy and paste of any notes taken. (family member recommendation).

Norfolk Police

Recommendation 14: That Norfolk Constabulary examine its policy on risk assessment in cases of familial domestic abuse incidents to ensure the focus on the alleged victim/complainant is not lost, and officers are supported in their professional judgement in risk assessing such cases.

Housing Departments

Recommendation 15: Local Authority Housing Departments when making enquiries to establish the status of a homeless applicant claiming to have been excluded from home, should ensure that the person said to have excluded them, and/or the accommodation owner should be spoken to independently to confirm whether they freely agree for the applicant to return, or to confirm they are excluding them.

University of Manchester

Recommendation 16: The University Counselling and Mental Health Service should examine its threshold for deciding when the enhanced welfare check and assessing a student in person is used and ensure decision making is informed by information from all support services, and academic departments involved in the student's University life, plus external sources who have provided information such as family or guardians if relevant and appropriate.

Individual Agency Recommendations from IMRs

Adult Social Care:

Recommendation 17: Whilst work has been done in SCCE about carers, and to remind adult social care staff to be reminded of the importance of identifying carers and providing information and referring to Carers Matters Norfolk for a carers assessment, it is recommended that ASSD has an increased focus on carers and the need to identify carers and refer for a carers assessment or provide information.

Recommendation 18: That there is a presentation at the AMHP Forum about learning from this IMR to include verbally handing over safeguarding concerns for others in the patient's home when the person is admitted to hospital and recording this on LAS.

Norfolk & Suffolk Foundation Trust (Mental Health Services)
Recommendations from IMR, Internal Review & Mental Health Homicide Review:

Recommendation 19: The trust will explore the possibility of additional scenario-based training in respect of mental capacity and application of the Act.

Recommendation 20: The trust will ensure that the mandatory domestic abuse, and safety planning and risk assessment training addresses assessment of risk relevant to all parties living within a household.

Recommendations 21: The panel concluded that contingency planning should have been more robust with additional information related to this shared with the family. Contingency planning within care plans should also be shared as required with involved services and related parties/carers.

Recommendation 22:
That the Mental Health Trusts roll-out of DIALOG and DIALOG+ system be maintained and reviewed, and in due course audited to ensure social, cultural, familial, and other patient - based information can be built into care in Norfolk more effectively.

Recommendation 23:
Contingency planning within care plans should also be shared as required with involved services and related parties/carers.

Recommendation 24:
The Trust will strengthen arrangements for assessments of safeguarding and teams (in team meetings and in supervision) and strengthen the way that they engage with families to maintain their professional curiosity about the wider impact in families. The clinical team should reinforce their policy for `Think Family'[111].

GP Practice / Integrated Care Board:

Recommendation 25: Norfolk and Waveney ICB to share the most current version of the Self-neglect and Hoarding Policy published on the Norfolk Safeguarding Adult Board Website with all GP practices in Norfolk and Waveney. This will be shared in a future Safeguarding primary care bulletin which is shared every month with GP practices. *Completed 30 May 2023, and June 2023 bulletin distributed.*

Recommendation 26: Norfolk and Waveney ICB to launch a template Domestic Abuse policy for all GP practices in Norfolk and Suffolk to be shared in 2022. *Completed: May 2023*

Recommendation 27: Norfolk and Waveney ICB to relaunch a revised policy template for Safeguarding Adults for all GP practices in Norfolk and Waveney to be shared in 2022. This to include a case-based scenario which covers assessment under the Mental Capacity Act (2005) and Autistic spectrum disorder in future Safeguarding Adult Level 3 teaching for primary care colleagues. *Completed: May 2023*

Norfolk Community Health & Care NHS Trust:

Recommendation 28: A message should be included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter to remind staff and raise awareness to be professionally curious when having discussions with patients about clutter and hoarding. It should be borne in mind that even after the environment being cleared and made 'safe' it is important to understand the triggers and root causes (if able) so that warning signs can be picked up as early as possible by both the patient and staff, and support strategies can be offered to the patient. This message should also be shared at

[111] Think Family' is an initiative that was introduced by the Department for Children, Schools and Families (DCSF) in 2008 following the Cabinet Office 'Families at Risk' Review. Since then, the approach has been expanded and developed, particularly in mental health services.

each of the local Place Governance and Quality meetings. This should be completed by End October 2022.

Recommendation 29: A message should be included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter to remind staff and raise awareness to be professionally curious when appointments are repeatedly cancelled/not attended and the source of information for the cancellation is not the patient. Staff should not automatically conclude that there is abuse occurring, but they should explore to ensure there is no controlling behaviour occurring. This message should also be shared at each of the local Place Governance and Quality meetings. This should be completed by end October 2022.

Recommendation 30: A piece of work should take place looking at and considering the development of a risk assessment relating to patients who do not attend appointments, or cancellations are made by people other than the patient themselves or there are safeguarding concerns. This could become part of the Safeguarding Adults Policy. The initial scoping of this risk assessment should be completed by end of July 2022. Any final risk assessment should be completed by the end of October 2022.

University of Manchester:

The following were developed jointly by the IMR author and DHR chair from the learning identified in the University's IMR.

Recommendation 31: Where concerns are raised about a student's behaviour and mental wellbeing, information should be gathered from all relevant pastoral, health support, and academic sources to inform a support plan. This should include the student's tutor who will have an up to date picture of their attendance and progress.

Recommendation 32: To bring clarity for staff regarding information sharing procedures when a family member raises concerns for the health and wellbeing of a student, but it is judged the circumstances do not meet the criteria for sharing personal information, the family member should routinely receive a follow-up phone call or email within 2 working days to summarise the concerns raised and confirm what actions were being taken. There will be very rare cases where this may be judged inappropriate (e.g., if the University is already aware that the student is estranged from their family) in which case this should be recorded.

Recommendation 33: When a family member has raised concerns about a student's wellbeing, notes of the information given by the family member and their concerns should be recorded, placed on the student's file, and a summary of their concerns emailed to the family member to ensure the summary is an accurate representation of the concerns.

Recommendation 34: Family members contacting the university with concerns about a student should have explained to them the limitations for sharing personal information about the student, when information can be shared, and the duties this places on the university's ability to provide detailed feedback. The university should consider producing a pdf leaflet explaining their information sharing policy which can be emailed to family members to enable them to digest and understand the policy in their own time. Also explain what exceptions are available in case the family members believes that some of the criteria have been met, so they can ask for the decision to be reconsidered.

Recommendation 35: That the University reviews the existing information provided on its website to ensure that there is a single, easily traced, and navigated pathway to make contact with concerns about a student 24 hours a day and that there is clarity about what anyone raising concerns can expect in terms of next steps.

Norfolk Constabulary

Recommendation 36: Non-intimate domestic abuse involving an Adult at Risk of Harm to be included in ongoing training events which are conducted yearly with all officers. This training should highlight professional curiosity and encourage officers to check on vulnerable adults within a domestic environment even when they are not the victim of the offence. This should highlight the specific terms relating to an Adult at Risk of Harm and increase officer RESTRICTED & CONFIDENTIAL 36 awareness of vulnerability, promoting completion of appropriate NCI (Non-Crime Investigations) and risk assessments.

Recommendation 37: Non-Crime Adult Protection Investigations with an associated risk assessment should be completed at any domestic abuse incident where an Adult at Risk of Harm is present as well as when they are a victim. Force Policy to be amended to include this requirement and provide clear responsibilities and governance.

Recommendation 38: The Norfolk Multi-Agency Safeguarding Hub will review any Non-Crime Adult Protection Investigation and consider information sharing with partner agencies where Adults at Risk of Harm are present or reside at a domestic abuse incident but not given victim status. This information sharing protocol is already in place but will encourage referral and risk consideration for those vulnerable adults who may be present or residing in addresses where a domestic abuse incident takes place. This is the same as would occur for a child or young person who is deemed to be at risk.

APPENDIX 1

DHR CHAIR/AUTHOR

The chair and report author for this Review is independent DHR chair and consultant Gaynor Mears OBE. The author holds a master's degree in Professional Childcare Practice (Child Protection) and it was during this degree she made a particular study of domestic abuse, its impact, the efficacy of multi-agency working, and the community coordinated response to domestic abuse. The author 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 of working in the domestic abuse field both in practice and strategically, including roles as a county domestic abuse reduction coordinator; setting up an Independent Domestic Violence Advocacy (IDVA) Service; in crime reduction 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. She was also regional 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, Multi-Agency Risk Assessment Conferences, Sexual Assault Referral Centres, and Specialist Domestic Violence Courts, supporting Partnerships with their implementation.

As an independent consultant Gaynor Mears has undertaken research and evaluations into domestic abuse services, a Specialist Domestic Abuse Court, management of high risk domestic abuse offenders, and best practice. She has been undertaking DHRs since they were introduced in 2011; these have involved both intimate partner abuse and adult family abuse, a proportion of which have been joint Child Practice Reviews, Safeguarding Adult Reviews and Mental Health Homicide Reviews. She has delivered presentations on the DHR process and its implementation and taken part in Home Office consultations on revisions to DHR Statutory Guidance. Gaynor Mears has also served as a trustee of a charity delivering Respect accredited community perpetrator programmes. She was awarded an OBE for services towards tackling domestic and sexual violence in 2010.

APPENDIX 2

UNIVERSITY OF MANCHESTER PROCESS FOR ACCESSING STUDENT SUPPORT SERVICES

A disclosure by a student which may indicate a need for additional support triggers a process through which a student's support needs are considered and an appropriate support package is put in place.

In addition, if a student makes a mental health declaration at any time during the course of their University life, the approach taken can be summarised as follows:

a. If a student discloses immediate life threatening risk to any member of staff who is not a mental health professional, the protocol is to call the emergency services and (if the student is on site), the University's Security Team.

b. If the risk were significant but not immediate, the student would be urgently referred to the Counselling and Mental Health Service for a same day appointment.

c. At that appointment a risk assessment would be conducted following usual clinical guidelines, this includes actuarial – using the CORE measure – and clinician assessment.

d. If the risk is significant and imminent, then an urgent referral to NHS mental health services would be made – this may include accompanying the student to A&E.

e. If the risk is significant but not imminent, a safety plan would be completed with the student, which would include sources of support and action to take if the risk escalated.

f. A plan for further support or intervention would be made – which would likely include a series of sessions with the Counselling and Mental Health service, referral to the Greater Manchester Student Mental Health Hub, and/or referral to external agencies. At each subsequent session a further risk assessment would be done, again using both the CORE measure and clinician assessment. We would work with the students to involve others within the university to create a network of support - e.g., Residential Life, school support, our Advice and Response team.

g. If a student self refers to the Counselling and Mental Health Service the brief booking questionnaire asks if they have concern for their immediate safety – which takes them to a page asking them to call the service immediately alongside identifying other crisis support .

Similar processes and considerations to those outlined above are followed in the event that concerns regarding a student's mental health are disclosed to the University by someone other than the student themselves (for example, by another student, a member of staff, a family member, etc.).

APPENDIX 3

UNIVERSITY OF MANCHESTER
INFORMATION FOR STUDENTS PRIOR TO AND DURING
THE ACADEMIC YEAR ON WELLBEING

Information about mental health, practical advice and guidance and details about how to access further support was provided in a variety of ways to all students both prior to and during the academic year, including in the orientation information at the start of the year. The primary examples in this context are:

- All students received a module before the start of year that covered consent/healthy relationships, wellbeing, mental health and resilience. The module also included links to sources of support at the end of the wellbeing section.
- In addition to this module, there was a specific Welcome website, which was updated during the year (not all students register from September and some only travelled to Manchester in January 2021). This site included information about health and wellbeing, sources of support and links to other information detailed in this response.
- In the Get Ready Guide, which was sent to all new students, is a section on wellbeing and student support that links through to the Welcome webpage. This information was sent to students on a number of occasions prior to the start of year.
- On 22nd September the weekly all student email shots commenced for the year. In this first edition was a section called 'Meet your services' that again reminded students about the range of support services available to them (from a health and wellbeing perspective, but also more broadly in terms of aspects like careers guidance).
- The following week, on 29th September the newsletter included articles on:
  - How to settle into (and enjoy living in) student accommodation; this included a reminder about the support from the Residential Life team;
  - Learning to take care of yourself (advice on emotional wellbeing and mental health);
  - A guide to self-isolation.
- Throughout the year, there was a regular focus in student communications on mental health and wellbeing. For example, during January a month long suicide prevention campaign entitled 'You're not alone' ran. It featured a range of messages and other interventions, but was focused specifically on students in distress or experiencing crisis. The campaign also sought to increase staff awareness of such issues and gave details of where to seek advice.
- Each course has a student handbook that includes information.
  - The Undergraduate Support Office, key staff in the School, the role of academic tutors and advisors and contact details for named student support and welfare officers.
  - There were also links to the key University-level services such as student support, mental health and disability support, and information about Nightline, a confidential out of hours listening and support line.
- The University has an extensive student support website, which has links to information and support about mental health available from its front page.
- A series of student FAQs on Covid were first introduced in March 2020 and have been updated regularly ever since. These are brought to students' attention through the weekly email newsletter and include details about wellbeing.
- Much of the content above was also issued through some of the University's student social media channels.
- For students in halls of residence, as Brenna was, there are specific webpages on wellbeing, with one focused on mental health, which highlights prominently the role of the Residential Life team in being a source of support, particularly for students who are having suicidal thoughts. It also lists other sources of support both within and outside of the University. This information was also part of the specific residences welcome minisite.

- As students moved into their hall of residence they each received a '*Welcome to Halls*' email. This contained a range of information including a mandatory online Welcome Course, tips on settling in, hall events, a link to the *Welcome to Halls* book and details about relevant Residential Life team contacts.
- Within the Welcome to Halls online course, the most relevant sections are on:
  - The Role of the Residential Life team (including highlighting their role in supporting mental health and wellbeing and how to contact them, including in an emergency situation or out of hours);
  - An introduction to the University's student support services, including the Counselling and Mental Health Service.
- Within the *Welcome to Halls* book, the most relevant sections are on:
  - A section on many aspects of wellbeing, including mental health.
  - A contacts section, which included details for the Residential Life team, the Counselling and Mental Health Service, Disability Advisory and Support Service, The Students' Union Advice Service, Nightline, The Samaritans, Papyrus, Shout, Togetherall mental health support service (at that time called Big White Wall).

APPENDIX 4

LINKS FOR INFORMATION ON ASSISTIVE TECHNOLOGY

Information on assistive technology can be found on the following websites:

Assistive technology - Norfolk County Council

Assistive Technology - Carers Matter Norfolk : Carers Matter Norfolk

Or to ask for a referral to the Assistive Technology Team at Norfolk County Council: **contact our Customer Service Centre** to ask for a referral to the Assistive Technology team.

NB:

All practitioners should ensure full information is given on the range of assistive technology available, including smoke and carbon monoxide detectors etc, and the backup provided by telecare systems. This is especially important when a pendant alarm is recommended or provided to ensure holistic safety and protection measures are in place.

APPENDIX 5

EXPLANATION OF POLICE POWERS TO REMOVE OR ARREST

Brennan was not arrested or removed from the premises. To aid understanding, it is necessary to consider the relevant police powers which explain why this might have been the case:

Police powers of arrest without warrant are covered by the Police and Criminal Evidence Act 1984 (PACE). The power to arrest a person who is involved, or suspected of being involved, in a criminal offence must be used fairly, responsibly, in a proportionate manner and consider if the necessary objectives can be met by other, less intrusive means.

There are several grounds on which an arrest can be made but they include:

- where an offence has been committed and a person is guilty or whom they have reasonable grounds to suspect is guilty of it.
- when they have reasonable grounds to suspect that an offence has been committed, anyone whom they have reasonable grounds to suspect of being guilty of it.

Arrest powers can only be exercised provided they have reasonable, objective, grounds to believe that it is necessary in order to… [there are then various criteria]. These criteria include:

- To prevent the person causing physical injury to themselves or any other person,
- To allow the prompt and effective investigation of the offence or of their conduct
- At least one of the necessity criteria must be met. There must be some reasonable, objective grounds for the suspicion based on known facts and information which make it likely the offence has been committed and that the suspect committed it.
- It remains an operational decision at the discretion of the arresting officer as to what action they may take at the point of contact with the individual.

Police powers in relation to Mental Health are primarily derived from Section 136 of the Mental Health Act 1983. In order to detain a person under S136 a police officer must be satisfied that the individual:

- Is in a public or private place (excludes dwelling – unless trespassing or communal)
- Appears to be suffering from a mental disorder and is in immediate need of care and control.
- It must be necessary to removed them to a place of safety in their own interest or for the protection of others. Before exercising their powers, officers are required to consult one of a number of specified health professionals.

Consideration has been given to ‘The Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020 and any potential breaches associated with Brennan having attended the address in December 2020. COVID related regulations changed frequently and the constabulary approach towards enforcement has been to use it only as a last resort. Given the circumstances of the situation at the address, if there had been any breach of the relevant regulations in force at the time there would not have been an arrest. Engagement and explaining was the Norfolk Constabulary approach in these cases, only escalating to arrest in the most serious of circumstances.

The above are the very basics of the legislation. In December 2020 Brennan was inside a dwelling, he was not trespassing and he had not committed any criminal offence which would necessitate his arrest.

Cambridgeshire & Peterborough Older People's Domestic Abuse Risk Assessment

APPENDIX 6

Date Completed:

CURRENT SITUATION THE CONTEXT AND DETAIL OF WHAT IS HAPPENING IS VERY IMPORTANT. THE QUESTIONS HIGHLIGHTED IN BOLD ARE HIGH RISK FACTORS. TICK THE RELEVANT BOX AND **ADD COMMENT** WHERE NECESSARY TO EXPAND.	YES ☑	NO ☑
1. Has the current incident resulted in injury or has there been injury in the past? (please state what and whether this is the first injury)	☐	☐
2. Are you very frightened? Comment:	☐	☐
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)….. might do and to whom) Kill: Self ☐ Children ☐ Other (please specify) ☐ Further injury and violence: Self ☐ Children ☐ Other (please specify) ☐ Other (please clarify): Self ☐ Children ☐ Other (please specify) ☐	☐	☐
4. Do you feel isolated from family/ friends i.e., does (name of abuser(s)….) try to stop you from seeing or talking to friends/family/GP or others?	☐	☐
5. Are you feeling depressed or having suicidal thoughts?	☐	☐
6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?	☐	☐
7. Do you have any health issues that make it hard for you to protect yourself? (please state what)	☐	☐

Cambridgeshire & Peterborough Older People's Domestic Abuse Risk Assessment

8. Does (…..) display any of the behaviours below? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done) **If answer is yes, ask the following questions. If No, continue to Q9**	☐	☐
A. Is there a previous domestic abuse and/or harassment history?	☐	☐
B. Had the perpetrator vandalised or destroyed property?	☐	☐
C. Does the perpetrator often turn up unannounced?	☐	☐
D. Has the perpetrator threatened physical or sexual violence?	☐	☐
E. Has the perpetrator been harassing any third party since the harassment began?	☐	☐
F. Has the perpetrator acted violently towards anyone else?	☐	☐
G. Has the perpetrator engaged others to help? (wittingly or unwittingly)	☐	☐
H. Is/has the perpetrator abusing/been abusing alcohol/drugs?	☐	☐
I. Has the perpetrator been violent in the past? (physical & psychological)	☐	☐
J. Does the perpetrator insist on staying with you for medical appointments or other m	☐	☐
CHILDREN/DEPENDENTS (If no children/dependants, please go to the next section)	YES	NO
9. Are there any children, (ie Grandchildren/Great grandchildren) in the household or who visit regularly?	☐	☐
10. Has (…..) ever hurt the children or been abusive in front of them	☐	☐
DOMESTIC VIOLENCE HISTORY	YES	NO
11. Has the abuse been happening for a long time?	☐	☐
12. Is the abuse happening more often?	☐	☐
13. Is the abuse getting worse?	☐	☐
14. Does (…….) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider honour based violence and stalking and specify the behaviour)	☐	☐
15. Has (…..) ever used weapons or objects to hurt you?	☐	☐
16. Has (…..) ever threatened to kill you or someone else and you believed them?	☐	☐

Cambridgeshire & Peterborough Older People's Domestic Abuse Risk Assessment

17. Has (…..) ever attempted to strangle/choke/suffocate/drown you?	☐	☐
18. Does (….) do or say things of a sexual nature that physically hurt you or that you don't want? (Please specify who and what)	☐	☐
19. Is there any other person that has threatened you or that you are afraid of? (If yes, consider extended family if honour based violence. Please specify who)	☐	☐
20. Has (…..) ever mistreated an animal or the family pet?	☐	☐
ABUSER(S)	YES	NO
21. Is the person that is abusing you also providing care for you (formal or informal) or are you caring for them?	☐	☐
22. Is the person that is abusing you an immediate family member? (please indicate) Partner (or ex) ☐ Son ☐ Daughter ☐ Son-in-Law ☐ Daughter-in-law ☐ Grandchild ☐ (please state if abuser under 18)	☐	☐
23. Are there any financial issues? For example, are you dependent on (…..) for money or are they dependent on you for money?	☐	☐
24. Has (…..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (Including dementia related illness) Drugs ☐ Alcohol ☐ Mental Health ☐	☐	☐
25. Has (….) taken money from you without your consent, or pressured you into giving them money?	☐	☐
26. Has (…..) ever threatened or attempted suicide?	☐	☐
27. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify) DV ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐

Cambridgeshire & Peterborough Older People's Domestic Abuse Risk Assessment

Professional Judgement: • **Other relevant information (from victim or professional) which may alter risk levels?** • **Consider the victim's situation in relation to disability or health issues, substance misuse, and mental health concerns?** • **Consider if the victim is reliant on the abuser for care of any sort (including help with managing the household, collecting shopping or medication as well as personal care), consider the impact of losing this support on the victim** • **Cultural/language barriers, 'Honour based' systems, geographic isolation and minimisation?** • **Consider the abuser's occupation/interests/ criminal associates/lifestyle habits, including access to firearms/weapons?** • **What are the victim's greatest priorities to addressing their safety?** **Please note that the current threshold for Cambs MARAC referrals: 17 or above on attached Safe Lives Dash risk assessment or on evidenced professional judgement which should be evidenced by your stating additional risk factors that are not asked about in this assessment form. Please refer to attached guidance notes on risk indicators to assist you in completing this form. If you need any further assistance please call the MARAC Co-ordinators or a Duty IDVA on 01480 847718.**		
Any other relevant risk led information.		
Are any other professionals or services involved with the victim? In some cases it may be appropriate to liaise with all services that are working closely with the victim to help with safety planning		
Has a referral been made to the Adult Safeguarding Team? **Outcome of Adult Safeguarding Referral (if known)**	☐	☐

Cambridgeshire & Peterborough Older People's Domestic Abuse Risk Assessment

Older People's Dash risk checklist

These notes are to help you understand the significance of the questions on the checklist. This checklist can be used for domestic abuse in any context – intimate relationships, family violence and for situations of 'honour'-based violence. Domestic abuse can include physical, emotional, mental, sexual, or economic abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

The purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a Marac meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

Practitioner guidance around working with older victims/survivors of domestic abuse is available at Welcome to Cambridgeshire DASV Partnership (cambsdasv.org.uk)

The Dash risk checklist should be introduced to the victim within the framework of your agency's:

- Confidentiality Policy
- Information Sharing Policy and Protocols
- Marac Referral Policies and Protocols

Before you begin to ask the questions in the Dash risk checklist:

Consider if the person has care and support needs and may meet the criteria for Adult at Risk under the Care Act (2014). If this is (or you suspect it to be) the case, please follow your agency Adult Safeguarding Procedures to make a referral to the Adult Safeguarding MASH Team.

- Establish how much time the victim has to talk to you: is it safe to talk now? What are safe contact details?
- Establish the whereabouts of the perpetrator and any children that may be in the household.
- It is important to talk to the victim on their own – the perpetrator may try to insist that they need to stay in a carer capacity and the victim may feel coerced into denying any abuse if they know the perpetrator is close by. It is sometimes useful to link up with another agency to carry out the DASH (i.e., District Nurse who may ordinarily see the victim on their own)
- Explain why you are asking these questions and how it relates to the Marac.

While you are asking the questions in the Dash risk checklist:

- Identify early on who the victim is frightened of – ex-partner/partner/family member.
- Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible, environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.

Asking about types of abuse and risk factors

Physical abuse

- Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation. The first question asks about previous injury as well as current injury. This is because, with older people, they may have been experiencing abuse for a number of years that

has been physical but the current incident may not have been physical if the health of the perpetrator has meant that physical abuse is now more difficult to inflict.

- You should try and establish if the abuse is getting worse, or happening more often, or the incidents themselves are more serious. If your client is not sure, ask them to document how many incidents there have been in the last year and what took place. They should also consider keeping a diary marking when physical and other incidents take place.
- Try and get a picture of the range of physical abuse that has taken place. The incident that is currently being disclosed may not be the worst thing to have happened.
- Consider injuries that initially appear to be inflicted accidentally in the context of 'providing care' such as bruises, also consider neglect of injuries or wounds (i.e., untreated pressure ulcers).
- Consider changes in behaviour of the perpetrator that could link to health issues i.e., dementia, change of medication, but remember these should not be attributed as causes of domestic abuse.
- Sometimes violence will be used against a family pet.
- If an incident has just occurred the victim should call 999 for assistance from the police. If the victim has injuries they should try and get them seen and documented by a health professional such as a GP or A&E nurse.

Sexual abuse

- Sexual abuse can include the use of threats, force, or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons.
- Do not assume that sexual abuse does not happen to older people. Equally, the victim may need reassurance that marriage does not mean an entitlement to sex. Remember that older victims may be very reluctant to discuss issues around sex, but questions need to be asked sensitively.
- If the victim has suffered sexual abuse you should encourage them to get medical attention and to report this to the police. See above for advice on finding a Sexual Assault Referral Centre which can assist with medical and legal investigations.

Coercion, threats and intimidation

- It is important to understand and establish: the fears of the victim/victims in relation to what the perpetrator/s may do; who they are frightened of and who they are frightened for. Victims usually know the abuser's behaviour better than anyone else which is why this question is significant.
- If the abuser is also providing any type of care and support for the victim, the victim will likely be very fearful of what will happen if they report the abuse. They may be concerned that they will need to leave their home or that they will need to have carers from outside the family.
- In cases of 'honour' based violence there may be more than one abuser living in the home or belonging to the wider family and community. This could also include female relatives.
- Stalking and harassment becomes more significant when the abuser is also making threats to harm themselves, the victim or others. They might use phrases such as "If I can't have you no one else can…"
- Other examples of behaviour that can indicate future harm include obsessive phone calls, texts or emails, uninvited visits to the victim's home or workplace, loitering and destroying/vandalising property.
- Advise the victim to keep a diary of these threats, when and where they happen, if anyone else was with them and if the threats made them feel frightened.
- Separation is a dangerous time: establish if the victim has tried to separate from the abuser or has been threatened about the consequences of leaving. Being pursued after separation can be particularly dangerous.
- Victims of domestic abuse sometimes tell us that the perpetrators harm pets, damage furniture and this alone makes them frightened without the perpetrator needing to physically hurt them. This kind of intimidation is common and often used as a way to control and frighten.

- Some perpetrators of domestic abuse do not follow court orders or contact arrangements with children. Previous violations may be associated with an increase in risk of future violence.
- Some victims feel frightened and intimidated by the criminal history of their partner/ex-partner. It is important to remember that offenders with a history of violence are at increased risk of harming their partner, even if the past violence was not directed towards intimate partners or family members, except for 'honour'-based violence, where the perpetrator(s) will commonly have no other recorded criminal history.

Emotional abuse and isolation

This can be experienced at the same time as the other types of abuse. It may be present on its own or it may have started long before any physical violence began. The result of this abuse is that victims can blame themselves and, in order to live with what is happening, minimise and deny how serious it is. As a professional you can assist the victim in beginning to consider the risks the victim and any children may be facing.

- The victim may be being prevented from seeing family or friends, from creating any support networks or prevented from having access to any money.
- Where the abuser is providing care or support to the victim, they may be making the victim feel that they are a 'burden' and that they cause the abuse. Caring responsibilities cover support with finances and household management as well as providing personal care. Consider if a carer assessment has been done and always think about disguised compliance. It may also be the case that the victim is providing care to the abuser.
- Victims of 'honour' based violence talk about extreme levels of isolation and being 'policed' in the home. This is a significant indicator of future harm and should be taken seriously.
- Due to the abuse and isolation being suffered victims feel like they have no choice but to continue living with the abuser and fear what may happen if they try and leave or make the abuser leave. This can often have an impact on the victim's mental health and they might feel depressed or even suicidal.
- Equally the risk to the victim is greater if their abuser has mental health problems such as depression and if they abuse drugs or alcohol. This can increase the level of isolation as victims can feel like agencies won't understand and will judge them. They may feel frightened that revealing this information will get them and their abuser into trouble.
- Where the abuser is a family member (i.e., adult child or in-law) they may be pressurising the victim for money to support drug or alcohol dependency. Consider that the victim may be very unwilling to get their own child into trouble by reporting the abuse to the police.

Children

- The presence of children including grandchildren can increase the risk of domestic abuse. They too can get caught up in the violence and suffer directly by witnessing the abuse.
- Please follow your local Child Protection Procedures and Guidelines for identifying and making referrals to Children's Services.

Economic abuse

- Victims of domestic abuse often tell us that they are financially controlled by their partners/ex-partners. Consider how the financial control impacts on the safety options available to them. For example, they may rely on their partner/ex-partner for an income or do not have access to benefits in their own right. For many older people it is traditional for the male partner to control the finances and a female victim may not have any resources in her own name, not even a bank account.
- Consider if the victim's benefits are being misused by the abuser – i.e., do they have access to their pension or are they claiming other benefits in the victim's name?
- If the victim owns their property, the abuser may have made them sign it over to them. The abuser could also be living in a property where they should not be living (i.e., moved in to parents rented property) but consider that the victim is unlikely to want to make a family member homeless.

Cambridgeshire & Peterborough Older People's Domestic Abuse Risk Assessment

- The Department for Work and Pensions have safeguarding leads that can assist with individual cases around safeguarding.

Revealing the results of the Dash risk checklist to the victim

Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to Marac and Children's Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management.

Cambridgeshire & Peterborough
Domestic Abuse & Sexual Violence Partnership

Devised and kindly provided by Amanda Warburton-Wynn

For accompanying report see:

Older People's DASH Public report FINAL.pdf
Cambridgeshire County Council DASV Partnership - The DASV Partnership (cambsdasv.org.uk)

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Appendix 7

Liam Bannon
Community Safety Manager
Community Safety and Violence Reduction Coordination Team
Office of the Police and Crime Commissioner for Norfolk Jubilee House
Falconers Chase
Wymondham Norfolk
NR18 0WW

24th June 2024

Dear Liam,

Thank you for submitting the Domestic Homicide Review (DHR) report for (Sofia) on behalf of Norfolk Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 22nd May 2024. I apologise for the delay in responding to you.

The QA Panel noted that the report demonstrated a strong desire to learn from the victim's death and apply those learnings to improve responses to familial domestic abuse and reduce the likelihood of future familial homicides both locally and nationally. There was positive engagement with Sofia's family who contributed to DHR process supported by advocacy after fatal domestic abuse (AAFDA) and Victim Support. There is a good sense of who Sofia was and the importance to her of being a mother and grandmother.

The inclusion of technical information, such as diagnoses or relevant legislation, was clearly explained and the inclusion of research regarding early cannabis use and psychosis benefited the analysis within the report.

It was also positive that a Mental Health Homicide Review was commissioned by NHS England and that the chair of that report was a panel member and learning from that report was included within the DHR. The Panel commended this as good practice and advised that this report was thoughtful, thorough and informative.

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 independence of panel members should be stated at 1.27.
- The action plan needs to be completed prior to publication. There is some text in highlight, and on page 30, that appears to be questions for the relevant agency.
- A specialist was not included on the panel to consider the impact of the

perpetrator's protected characteristics of his dual nationality and experience of moving to a new country with differences in culture and language. The CSP may wish to consider this for any future DHRs undertaken.

- Brennan's father told the police who attended in December 2020 that Sofia was deaf and would not have heard anything, but this is not explored or mentioned elsewhere. It would be helpful to clarify if there were any medical interactions around Sofia's hearing, or if others had experience with her loss of hearing.
- The safeguarding issue that was raised about Sofia's eldest son and father of Brennan was not analysed in depth. For example consideration of why he left Sofia's home the night of the fire as he was in fear of his son but had not considered taking his elderly mother with him, who disclosed that struggled with Brennan.
- 'Sofia' is currently spelled differently in the filenames for the overview and executive summary.
- There are some inconsistencies in the data collection sheet that need to be addressed. For example the date of Sofia's death and her ethnicity (which is listed as White British but the review states she was born in Sweden).
- A pseudonym for Brennan's father could help improve readability.
- The report requires a proofread prior to publication.

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

Appendix 8

Response to Quality Assurance Panel Feedback

Bullet Point 1: Additional text added at paragraph 1.27 confirming independence of Panel members.

Bullet Point 2: The Action Plan is a living document which will be updated in the period of time following approval by the Quality Assurance Panel. A suitable updated plan will be attached and published with the DHR documents, but it will continue to be updated until actions are fully completed.

Bullet Point 3: A specific Panel member to advise on dual nationality and experience of moving to a new country with differences in culture and language, was not considered due to the (a) difficulties in finding such expertise and (b) Panel attendance by voluntary sector services frequently proves challenging for their resources. The undoubted additional stress moving countries and cultures can involve was discussed by Panel, and the Mental Health Homicide Review and Mental Health Individual Management Review acknowledged, i.e. paragraph 5.64. Had the perpetrator agreed to an interview this would have been explored further. Any future DHR Panels will however, give further consideration to the breadth of expertise required.

Bullet Point 4: Re: Sofia's hearing loss. This is not only mentioned in the December 2020 Police attendance record, but Sofia's hearing difficulties are mentioned several times in the Overview Report see: paragraphs 3.50, 3.58, 4.19 (evidence from an external carer), 5.16, 5.185.

Bullet Point 5: The only safeguarding referral made was in July 2019. Regarding the feedback question of why Brennan's father did not take his mother with him when he left the house in December 2020; this was not examined in depth as the DHR was specifically charged with examining the actions of Brennan the perpetrator of the crime, and the actions of the services involved. Whilst a DHR has a duty to examine what *agencies* could or should have done differently to prevent future domestic homicides, statutory guidance also charges DHR's to examine agencies actions whilst avoiding personal blame. It is not within the remit of the DHR to examine the actions of private individuals who may be under extreme duress.

Bullet Point 6: The difference in file name has been corrected.

Bullet Point 7: The data sheet has been corrected.

Bullet Point 8: It would be inappropriate to return to the family to negotiate a suitable pseudonym for Brennan's father after the completion of the Review and the time which has elapsed in receiving feedback. The family has experienced significant upset and stress throughout this time, and it is not justifiable to revisit the Review for this matter. In addition, the time required to make amendments would lead to delays in publication. Future DHR Panel's will note this feedback for any future DHRs however.

Bullet Point 9: A further proofread has taken place and identified amendments made.

Appendix 9

NATIONAL RECOMMENDATIONS

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
What is the Recommendation to be actioned?	*National, regiona or local level*	*How is the agency to make this recommendation happen? What actions need to occur?*	*Lead Role/Job Title*	*Key milestone and date to be completed*	*Completion of recommendation*	
Recommendation 1: **Independent Office for Police Conduct Recommendation:** To avoid delays in the completion of a Domestic Homicide Review where an IOPC inquiry is taking place concurrently, the IOPC concluding report should be expedited promptly, and made available to the DHR Panel within 6 months of the verdict concluding the criminal trial to enable all relevant information to be included in the Review. Where the IOPC cannot conclude its report within this time it should write to the relevant DHR chair and Community Safety Partnership chair with a full explanation of the delays and a deadline for completion.	National	The IOPC to review its processes and ensure prompt completion of IOPC enquiries and to make them available to DHRs within 6 months of the completion of the criminal justice process..	**Independent Office for Police Conduct**	IOPC to review processes and timescales of reports to be provided to DHRs within 6 months of the approval of this DHR by the Home Office. Outcome to be reported to the Norfolk Community Safety Partnership via: NCCSP@norfolk.police.uk.cjsm.net	*To be set*	Outcome: DHRs provided with IOPC reports to DHRs within 6 months of the completion of the criminal justice process to prevent delay iln the completion of the DHR. Date Completed:
Recommendation 2: **NHS England Recommendation:**	National	NHS England to examine a mechanism to build mandatory training on all aspects of domestic abuse	**NHS England**	In consultation with the professional body for GPs protected mandatory training on	*To be set*	Outcome: GPs in England & Wales receive domestic abuse training to equip them

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
That NHS England examine the efficacy of mandatory dedicated domestic abuse training for all GPs as part of their continuing professional development to enable them to keep up to date with all aspects of domestic abuse and the support services available in their area. If possible, training time should be protected to enable GPs to attend.		into protected GP professional development as part of contracts.		domestic abuse introduced for GPs. Progress to be emailed to: NCCSP@norfolk.police.uk.cjsm.net		to support victim of intimate partner and familial abuse safely and effectively. Date Completed;
Recommendaton 3: **National Institute for Clinical Excellence (NICE):** NICE guidelines on hospital discharge should be revised to include ensuring consideration of vulnerable persons residing in the accommodation to which the patient/service user is returning; specifically in respect of any risks to others the patient/service user may pose to other occupants. The policy must outline the need to undertake and document assessment of risk or abuse; whether information should be shared with other residents or carers to maintain safety;	National	NICE guidelines examined and revised to include a requirement to consider vulnerable people and their wellbeing who are in the household to which a patient is to be discharged..	**National Institute for Clinical Excellence (NICE)**	Practice guidelines put in place to ensure the needs of vulnerable people are considered before a patient is discharged into a household or accommodation. Progress to be emailed to: NCCSP@norfolk.police.uk.cjsm.net	*To be set*	Outcome: Discharging procedures require risks to vulnerable people are considered before a patient is discharged and alternative accommodation is arranged if required to ensure vulnerable adults and/or children are safeguarded Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
whether a referral to the local safeguarding team/lead or MASH team should be considered, and if a referral to MAPPA or MARAC is needed, or consideration of a Potentially Dangerous Person (PDP) referral to local police.						
Recommendation 4: Department of Health & Social Care: The Department of Health & Social Care should consider a public health awareness raising campaign for secondary school aged children and young people with the aim of highlighting the negative impact on mental health of early and frequent cannabis use.	National	Design and content of campaign discussed and planned.	**Department of Health & Social Care**	Timing and scope of campaign agreed and actioned across various media and throughout schools in England & Wales. Progress to be emailed to: NCCSP@norfolk.police.uk.cjsm.net	*To be set*	Outcome: Children and young people aware of the adverse impact of cannabis on long term mental health and a reduction in early onset psychosis diagnosis. Date Completed:
Recommendation 5: Department of Health & Social Care, Home Office, & Domestic Abuse Commissioner for England & Wales: That the Department of Health & Social Care, and Home Office in collaboration with the Domestic Abuse Commissioner for England & Wales commission urgent research to	National	Terms of reference for research set to achieve the desired outcome of the impact of coercive control being considered as a separate criteria for undertaking Section 42 Enquires where a person has mental capacity and is	**Department of Health & Social Care, Home Office, with the Domestic Abuse Commissioner**	Research designed and ethical clearance achieved. Research and recommendations for desired outcome completed. Recommendations consulted upon and revisions to statutory guidance enacted as required	*To be set*	Outcome: Victims and vulnerable adults potentially impacted by coercive control but who have mental capacity are assessed under the Care Act and safeguarded as required.

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
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. The results of the research should be used to inform the review being undertaken by DHSC to strengthen and clarify the Care Act 2014 guidance.		declining involvement of services. Contract out for tender and research commissioned.	**for England & Wales:**	Progress to be emailed to: NCCSP@norfolk.police.uk.cjsm.net		Date Completed:
Recommendation 6: Department for Levelling Up, Housing & Communities: That statutory regulations governing Smoke and Cabon Monoxide Alarms be amended to include the requirement that all internet enabled alarms must be linked to a minimum of 2 devices to ensure alerts can be acted upon at all times. Manufacturers must ensure the system cannot become operational until this is done, and if a device has to	National	Amendment to statutory regulations drafted to achieve recommendation outcome.	**Department for Levelling Up, Housing & Communities:**	Amendment consulted upon and regulation changed to include requirement for a minimum of 2 devices to be linked to wi-fi smoke and carbon monoxide alarms. Progress to be emailed to: NCCSP@norfolk.police.uk.cjsm.net	*To be set*	Outcome: The safety of occupants of homes fitted with wi-fi enable safety equipment including smoke and carbon monoxide alarms is increased to reduce loss of life. Date Completed;

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
be deleted at any time another must be installed simultaneously to enable the system to function continuously with the provision of a minimum of 2 separate individuals to receive alerts.						

LOCAL, MULTI-AGENCY RECOMMENDATIONS

DHR Panel Recommendations						
Recommendation 1 : Domestic abuse training which includes intimate partner abuse and adult family abuse across the whole age range, and includes the impact on children, should be of a consistent content and standard, and mandatory for all public facing staff in the following services.***** Professional curiosity should be at the core of all training and, as is expected when children are present at the scene of a domestic abuse incident, training should include the need to check on the wellbeing of vulnerable adults present in the household. 6. Norfolk County Council services (provided or commissioned) involved in welfare, caring services, and safeguarding. 7. Community Health Care Services 8. Secondary Healthcare Service 9. Voluntary sector services commissioned by the local authority and CCG i.e., those supporting older people, carers, those living with addiction and/or	Local Multi-Agency	**NCSP** Establish a Domestic Abuse Training partnership group to audit domestic abuse training across the NCCSP. Provide recommendations to improve the training provided across the NCCSP membership,. Implement recommendations including agreeing NCCSP Domestic Abuse Training Standards. Age UK invited to join Training Group. **Age UK Norwich** All public facing staff in all Age UK Norwich services to attend Domestic Abuse Awareness Training. This would include any commissioned and non-commissioned services.	**NCSP** Community Safety Manager **Age UK Norwich** Chief Officer	**NCSP** Training Group established. Domestic Abuse Training Audit complete Practitioner survey complete – measuring practitioner experience. Domestic Abuse Training Standards agreed by training group. Domestic Abuse Training Standards agreed by DASVG. Domestic Abuse Training Standards implementation process agreed. Domestic Abuse Training Standards implementation delivered. **Age UK Norwich** Review quality of Domestic Abuse Training to ensure it covers the importance of professional curiosity and to include a particular focus on older people in line with the clients that we work with. Induction training to be reviewed..	**NCSP** Complete – Nov 22 Complete – Spring 23 Complete – Summer 23 Complete – Summer 23 Complete – September 23 Ongoing - December 2023 Ongoing – Spring 23 **Age UK Norwich** 31st March 2024	Outcome: CSP responsible authorities and relevant local charities assure themselves and the partnership that robust training is in place across all organisations, ensuring staff have the knowledge and skills to effectively identify and respond to domestic abuse. Date Completed:

mental ill-health including dementia/Alzheimer's disease. 10. Housing officers (District Council and Housing Associations). **NB** [112]		Domestic Abuse Awareness Training to be built into inductions for new public facing staff joining the organisation. Mandatory Domestic Abuse Awareness Refresher Training to take place bi-annually. **Norfolk County Council (NCC)** Application for funding via finance to examine a repeated suitable CPD accredited course across the range of commissioned services and provided services in NCC given the size of the potential cohort involved and mandatory nature of the recommendation. Examine with our training provider (St Thomas) re - examining ASSD domestic violence training for ASSD	**NCC** Director of Commissioning - ASC Head of Safeguarding - ASC Head of Safeguarding, Community Director of Social Work - ASC. Manager Learning and Development ASSD Manager Learning and Development ASSD /Head of Safeguarding - ASC , Head of	Rolling programme of training to be put in place. **NCC** Application and consideration of funding requirement by March 31/ 2024. If refused consideration of other options to extend training/information to the provider market etc. Consideration with Safeguarding training (St Thomas) provider to enhance current safeguarding training to include learning for the DHR/recommendation). On-line courses will require re-recording/format changes. Measure: the course adopts the recommendation. Domestic Violence course to adopt DHR recommendation with similar reformat and re-recording. Measure: Quality and policy team to audit training attendance and learning outcome/s on delivery of adjusted training.	31st March 2024 30th April 2024 **NCC** 01/09/24 if funding is granted. 01/03/24. 01/03/24	

[112] ***** It is recognised that Police and Probation have national level approved training with which they have to comply, and GP practices work within their NHS contract obligations therefore this training cannot be mandated. However, we are sure they would be welcome to attend county multi-agency domestic abuse training if resources allow.

		staff to include recommendations/learning. Examination of how the current safeguarding courses (St Thomas) with the emphasis on professional curiosity can include the added aspect of vulnerable adults and children as per DHR recommendation. **Norfolk Constabulary** As per Local Recommendation NC1 – All Norfolk Constabulary domestic abuse training to focus on professional curiosity & awareness of adults at risk of harm. The introduction of OPTIK (a mobile enabled policing tool – accessible at scene) has introduced the pneumonic RTHUR to prompt officers to consider the voice of the child. College of Policing approved new DA risk assessment has	Quality & Policy - ASC . **Norfolk Constabulary** Safeguarding Development Inspector **NSFT** Associate Director, Patient Safety and Safeguarding	**Norfolk Constabulary** Officers now have a mobile enabled online tool which will guide them and promote professional curiosity to improve information for assessments. **NSFT** NSFT refreshed all level 3 safeguarding training, which is mandatory for all clinical staff in 2023.	**Norfolk Constabulary** 31 October 2023 **NSFT** September 2023	**Norfolk Constabulary** Outcome: Improved awareness of vulnerable persons within addresses and increased professional curiosity – this is tested/measured at the conclusion of the training which is being delivered annually to all frontline officers. Completed:31/10/2023 **NSFT** Outcome: Improved awareness of vulnerable persons within addresses and increased professional curiosity –

		been rolled out across Norfolk. This encourages officers to use professional curiosity and has standardised this training cross both counties to all front line officers. **<u>NSFT</u>** Assure CSP that current training meets criteria of recommendation		CSP received assurance of compliance in July 2024 which confirmed all standards met.	July 2024	this is tested/measured at the conclusion of the training which is being delivered to all clinical officers. Complete – July 2024

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 2: All services should reinforce within their policies and procedures, and in staff supervision, the importance of professional curiosity, what this entails in practice, and: (e) Practitioners and their managers should be reminded of the steps to take as described in Safeguarding training with the aim of achieving the fullest, corroborated information for assessments as possible. (f) Anyone expressing concern for another person during an assessment or interview should be asked for examples and to describe those concerns, and this must be recorded in detail. (g) If a vulnerable person who requires assistance to attend appointments misses two or more appointments active	Local Multi-Agency	**Norfolk Safeguarding Adult Board** Review NSAB multi-agency policy and training content to ensure professional curiosity is given prominence and reinforcement across sectors in the county **NSFT** This is addressed via Trust Recommendation 22 - Roll out of DIALOG + which continues across the Trust will encourage professional curiosity & support staff to capture detailed information. This will be delivered via MEG recording		**NSAB** Policy and Train the Trainer review completed and amendments made where necessary and publicised to partners and agencies.	**NSAB** 04/01/2024	Outcome: By obtaining and recording the fullest information possible for all types of assessment, including the existence of LPA's, Vulnerable adults are more effectively supported. Information is corroborated wherever possible, particularly in any safeguarding enquires, and special attention is paid to vulnerable people missing a series of appointments. **NSAB** Additional handout to be added to Train the Trainer programme but professional curiosity is referenced throughout face to face teaching and refresher sessions as fundamental to practice. In addition NSAB has a specific guidance document on professional curiosity, a dedicated page on our website, and it is

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
enquiries should be made directly with that person to establish the reason and to ensure their wellbeing. **(h)** Enquiring whether an adult for whom a referral is made has a Lasting Power of Attorney should be routine, written into procedures, and details recorded to ensue where relevant they are consulted.		system, allowing for LPA and NOK recording Management supervision of practitioners to include ensuring professional curiosity has been evidenced in casework. Introduce clinical risk management policy, which covers promoting professional curiosity and all narrative risks to be considered. **Norfolk Constabulary** Norfolk Domestic Abuse Policy examined and amended to include submission of adult protection investigation and promote professional curiosity OPTIK (Mobile enabled policing tool – accessible at scene) amendments have been made to ensure that officers ask for and document an initial account in all cases of DA even when a crime has not been disclosed – this achieves the fullest information by encouraging professional curiosity.	**NSFT** Associate Director of patient safety and safeguarding NSFT **Norfolk Constabulary** MASH DI	**NSFT** MEG annual audit of system to ensure quality of information for assessments commences. Monthly clinical staff appraisal to include evidence of professional curiosity and quality of information in records. This uses a standard supervision template. In addition there is monthly safeguarding supervision for all staff. Finalise policy Implement policy **Norfolk Constabulary**	**NSFT** November 2022 July 2022 and audited monthly on ongoing basis October 2023 and audited monthly on ongoing basis July 2024 February 2025 **Norfolk Constabulary** 11/10/2023	explicit in NSAB DA and older adults guidance. NSAB continues to promote professional curiosity across the safeguarding adults network to embed as a key theme from SARs as well as DHRs. **NSFT** Annual MEG Audit outcomes Audit of monthly clinical and all staff supervisions Date Completed: **Norfolk Constabulary** Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		Age UK Norwich Age UK Norwich Domestic Abuse Policy and procedures to be reviewed to include specific reference to the importance of professional curiosity and making reference to points a - d when identifying cases of domestic abuse. Age UK Norwich policies regarding Safeguarding Adults and Children to be reviewed to ensure links made with our Domestic Abuse Policy. Staff in all Age UK Norwich services to be briefed and reminded of the importance of professional curiosity when dealing with cases of domestic abuse, including points a - d. Supervision sessions will continue to include discussions regarding cases of safeguarding and domestic abuse when these occur. **Norfolk County Council (NCC)** Supervision policy to be reviewed and adjusted as required in line with (R2).	**Age UK Norwich** Chief Officer **NCC**	Policy reviewed and amended in September 2023 Force policy change to be highlighted to officers in briefings and communications.(MASH DA Manager) monitoring as at 27th September 2023 OPTIK has been deployed to all frontline officers. **Age UK Norwich** Review of Domestic Abuse Policy to be completed. Review of Safeguarding policy to be completed. Staff briefings across all services to cover amended policies to be completed.	**Age UK Norwich** 31 March 2024 31 March 2024	11/10/2023 **Age UK Norwich** 30/092024

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		Safeguarding training and policy advice to be reviewed and adjusted if required as per recommendations. Policy review undertaken.	Professional Social Worker Head of Quality & Policy - ASC .	Staff supervision to include discussions on any safeguarding and domestic abuse cases – ongoing from –	30 September 2024 1 April 2024	**NCC** 1st December 2024
		Reinforcement in safeguarding training (St Thomas) and oversight by Safeguarding Social Workers appropriate recording standards. Professional curiosity and the practice implications of recommendation (1) to be examined via quality and practice team working with the safeguarding team.	Professional Social Worker/Head of Safeguarding - ASC /Head of Quality & Policy - ASC	**NCC** Changes to relevant policy and procedure advice and associated changes within training and supervision. To measure via quality and policy changes to practice via audit.	**NCC** 01/09/24.	
		To ensure integrated managers in the health and older people service operated via Norfolk Community Heath Trust are aware of this requirement on health appointments via S75 meeting.	Professional Social Worker/Head of Safeguarding - ASC /Head of Quality & Policy - ASC / Manager Learning and Development ASSD	Changes to relevant policy and procedure advice and associated changes within training regarding assessments. To measure via quality and policy changes to practice via audit.	01/06/24.	
		Reinforce existing policy and guidance on the differing aspects of a LPA to be reinforced and contact made with LPA holder when required.		Changes to training and audit process. Capture changes via training/cultural emphasis and associated management direction with quality and policy team via quality panel.		
		Examination of current policy and procedures and training to examine 'Think Family' is highlighted and training re-examined to reflect the	Integrated Health and		01/06/24.	

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		complexities of 'Think Family' approach vs the requirement to undertake proportionate assessments under the Care	Social Care Director	Ensure DHR recommendations are known to integrated service via S75 meeting and how DHR associated training and policy and practice changes flow into the integrated management structure.	01/04/24.	
		To re-examine current assessment forms to ensure tenancy or ownership details are requested.	Professional Social Worker/Head of Quality & Policy - ASC .			
			Head of Safeguarding, Community Director of Social Work - ASC/Professional Social Worker/Head of Quality & Policy - ASC /Integrated Health and Social Care Director	Reinforce existing policy and guidance on LPA via initial training. Ensure follow up training highlights this aspect of the DHR. Measure via quality panel.	01/04/24.	
				Examination of current policy and guidance and Care Act requirements to ensure a cohesive approach to the DHR recommendations via changes to policy and procedure, training and management instruction to be subject to quality and policy audit oversight via quality panel.	01/12/24. 01/04/24.	
		Integrated Care Board (ICB) Develop was not brought policy for GPs				

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
			Head of Quality & Policy - ASC . **ICB** Named GP for Safeguarding	Assessment form to be re-examined and changed to reflect the recommendation.		
		Provide MCA training to primary care professionals		A template policy titled "General Practice : Was Not Brought/Did Not Attend Policy for children, young people and vulnerable adults not brought to/not attending health appointments was developed in March 2023 by Norfolk and Waveney Integrated Care Board. The Norfolk Local Medical	March 2024	

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
				Committee were consulted as part of the development of the policy. The policy was reviewed and updated in March 2024 and shared again with all GP practices in Norfolk and Waveney to adapt to the needs of their practices. 8 x Full day Mental Capacity Act Courses run by Bond Solon were offered to the Norfolk & Waveney System from April 2022 to September 2023. The course covered: • Applying the principles of the Act to clinical practice • Making and documenting an MCA assessment • Reaching balanced and informed best interest decisions • Implementing best interest decisions • Assessing the validity and applicability of advanced decisions	September 2023	Feedback was collected from attendees who overwhelming gave a positive response.

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
				• Working with Donees • Referring to the OPG • Involving an IMCA. The courses were offered on a first come, first served basis to Primary Care colleagues, with 20 places per course; a limit placed by Bond Solon Feedback was collected from attendees who overwhelming gave a positive response. Training on the MCA is also delivered as part of the Level 3 Safeguarding Adults training which is delivered by the ICB Safeguarding Adult GP, and there are opportunities for case discussion within GP forums across the system. Information related to MCA including Lasting Power of Attorney, is shared via the GP Safeguarding Newsletter 'Spotlight' and it is posted within the Safeguarding Primary Care Teams Channel hosted by the ICB. This includes news updates, training events and useful information, including a monthly newsletter.		

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
				The Safeguarding Adult GP/Clinical Lead for MCA and Designated Members of the Safeguarding Team are available for consultation regarding MCA matters 5 days a week. The ICB has up to date policies and procedures on safeguarding and supervision readily available on ICB Intranet for ICB staff. Supervision offered to practitioners to include professional curiosity. All staff receive L1 Safeguarding training. Intercollegiate document followed for Safeguarding training competencies.		

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 3: All services undertaking assessments should take a 'Think Family' approach and: (c) use their full assessment skills and professional curiosity to ensure information for assessments, care plans and risk assessments is fully inclusive of all family members /family structure, plus any carers, and where relevant note who is the home owner or holder of a tenancy. (d) to ensure a 'Think Family' approach is embedded in organisational and cultural change at all levels, directors of services should ensure policies, training, and procedures promote this approach, clearly set out practice expectations, and audit this change in practice on a 6 monthly and then an annual basis.	Local Multi-Agency	**NSFT** "Think family" is to be embedded within assessment and risk formulation. **Norfolk Constabulary** All high and medium risk DA investigations are subject to secondary review in the multi-agency safeguarding hub. "Think Family" is embedded within this process and an assessment Is made of all risk factors within the family environment with referrals then made to the appropriate agency. **Norfolk County Council (NCC)** Examination of current policy and procedures and training to examine 'Think Family' is highlighted and training re-examined to reflect the complexities of 'Think Family' approach vs the requirement to undertake proportionate assessments under the Care	**NSFT** Associate Director of patient safety and safeguarding NSFT **Norfolk Constabulary** MASH DI **NCC** Head of Safeguarding, Community	**NSFT** Change project to run as a pilot in child and family services initially; to include genogram app, inclusion in mandatory training for all practitioners, amendments to templates as required including letters and correspondence with families, carers and other interested parties. Communication strategy. Audit against policy standards (6-12mths post implementation) **Norfolk Constabulary** Process already in place with amendments as per local recommendation NC3 to ensure that Adult Protection Investigations are submitted and shared where relevant. **NCC**	**NSFT** April 2024 **Norfolk Constabulary** Already completed **NCC** 1/12/2024	Outcome: A 'Think Family' approach is embedded in working practice and assessments, car plans, and risk assessments are informed by, and encompassing of, all relevant family members. Date Completed: **Norfolk Constabulary** Date Completed: 31/10/2023

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		Act and realities of holding lists in ASSD. To re-examine current assessment forms to ensure tenancy or ownership details are requested. To examine 'Think Family' with regards to social work and occupational therapy practice and associated training, and within supervision requirements given practice change. Examine how cultural change is audited with quality and policy team. **ICB** Share Think Family Approach messages through all-age Safeguarding Lead GP and deputy meetings	Director of Social Work - ASC/ Professional Social Worker/ Head of Quality & Policy - ASC / Integrated Health and Social Care Director . Head of Quality & Policy - ASC . Professional Social Worker/Head of Quality & Policy - ASC .	Examination of current policy and guidance and Care Act requirements to ensure a cohesive approach to the DHR recommendations via changes to policy and procedure, training and management instruction to be subject to quality and policy audit oversight via quality panel. Assessment form to be re-examined and changed to reflect the recommendation. Significant cultural change is required via this recommendation alongside changes in policy and procedure. First milestone is to re-examine all policy and procedure and training requirements. Measure: Quality and policy team to examine audit of change via quality panel.	1/4/24 01/12/24.	**NCC** 01/12/24.

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		Share Think Family Approach messages through DASAHF	**ICB** Lead GP for safeguarding	ICB Norfolk and Waveney Integrated Care Board (ICB) deliver monthly all-age Safeguarding Lead GP and deputy meetings as well as bimonthly safeguarding administrator meetings. Guest speakers span the all-age safeguarding arena thereby promoting the Think Family Approach. This Think Family approach is also incorporated into case based Safeguarding Adult training delivered by Norfolk and Waveney ICB as part of the Level 3 Safeguarding refresher and core training offer. Domestic Abuse and Sexual Abuse Health Forum chaired by SG ICB-an all age forum.		

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
				Membership of the DASAHF has representatives from health organisations to ensure the health system understands and engages in the response to the DA and SV agenda. Representatives from organisations or groups SG team within ICB mering to become an all age safeguarding team-All Age Safeguarding means protecting an adult's and child's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult and child's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.		

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 4: All local health inpatient and residential social care providers: To review, and revise where necessary, the providers Discharge Policy to ensure it covers consideration of vulnerable persons residing in the accommodation to which the patient/service user is returning; specifically in respect of any risks to others the returning patient/service user may pose to other occupants. The policy must outline the need to undertake and document: a) Assessment of risk criteria (risk of harm or abuse) b) Actions including whether or not information should be shared with other residents, or carers to maintain safety and/or a referral to the local provider safeguarding	Local Multi-Agency	**NSFT** Discharge policy C70a discharge from inpatient care will be reviewed to include this direction. **Norfolk County Council (NCC)** Commissioning to examine how contractual or training changes as per (4) are delivered and funded by provider commissioned services and to advise Norfolk	**NSFT** Director of nursing, patient safety and safeguarding **NCC** Director of Commissioning - ASC/ ICS Commissioners/ Norfolk Care Association. NHS ICS (lead agency).Director	**NSFT** Policy updated – December 2023 **NCC** Commissioners to meet with ICS and representatives of provider market in Norfolk as a first step to examining how providers both commissioned and not, meet this recommendation. Measure: Initial meeting to develop	**NSFT** December 2023 **NCC** 01/04/24.	Outcome: A system is in place which ensure those living in the household to which a service user is to be discharged are consulted and risk to others in the household are thoroughly assessed before discharge. Vulnerable adults and/or children in the household have any additional needs and risks assessed and this is revisited regularly to ensure the continuing safety of all members of the household. **NSFT** Date Completed: **NCC**

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
team/lead or MASH team. c) Also, to consider if a referral to MAPPA or MARAC is needed, or consideration of a Potentially Dangerous Person (PDP) referral to local police. • Assurance of this action must be provided to: For Health providers – the ICB Adult Safeguarding Lead/team For Socials Care providers – the local authority Head of Integrated Quality Service/team.		residential/nursing care association of this recommendation for providers who do not contract with NCC or the ICS. Hospital Discharge is an NHS function which ASSD works alongside various health providers to enact with them, and will work with changes to this policy. Safeguarding team to advise commissioning regarding referral process (a, b, c on risk). To examine with health and social care commissioners how such a risk assessment tool/ document is developed, and the range of requirements set out for the provider market. Key staff in domiciliary care, given the care offered to vulnerable people are included in recommendation 5.	of Commissioning - ASC/Head of Quality & Policy - ASC /Head of Safeguarding - ASC . Head of Safeguarding - ASC . ICS Commissioners/ Director of Commissioning - ASC/ Head of Safeguarding - ASC / Integrated Health and Social Care Director - ASC .	discharge plan and distribution. As per above. As per above.	01/04/24. 01/04/24.	

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 5: To reduce risk in adult family abuse cases it is strongly recommended that a task group is set up to investigate the use of a risk assessment tool by services when a safeguarding concern involves an allegation or risk of abuse within the family context which therefore meets the definition of domestic abuse. Where the safeguarding concern is about an older adult a suitably adjusted DASH designed for older victims could be considered for use e.g. The All Wales Risk Identification Checklist (RIC) for MARAC Agencies or Cambridgeshire & Peterborough MARAC Referral Form and Risk Indicator Checklist for Older People (over 60).	Local Multi-Agency	**Norfolk Community Safety Partnership /Norfolk Safeguarding Adults Board** DASVG (Domestic Abuse and Sexual Violence Group) looking at a working group to address the risk around DA within older adults. This has been identified as a real risk by police and we have multiple high risk cases involving older adults. This will be chaired by North Norfolk District Council and the older adult DASH will be considered. **Norfolk Constabulary** A risk identification matrix introduced in the domestic abuse safeguarding teams. This scans referrals and provides a weighted, priority score based on risk. To be amended to look to age and the increased vulnerability associated. **Norfolk County Council (NCC)** Examination of safeguarding forms to look at change or	**Norfolk Community Safety Partnership /Norfolk Safeguarding Adults Board** **Norfolk Constabulary** MASH DI **NCC** Head of Safeguarding - ASC	**Norfolk Community Safety Partnership /Norfolk Safeguarding Adults Board** T+F group established with the partial purpose of completing this recommendation/action T+F considers risk assessments **Norfolk Constabulary** Risk matrix to be amended. **NCC** Task group to be created to examine changes in the risk assessment tool used.	**Norfolk Community Safety Partnership /Norfolk Safeguarding Adults Board** 1/7/24 31/12/2024 **Norfolk Constabulary** 31/12/2023 **NCC** 01/04/2024	Outcome: A risk assessment is achieved which assists practitioners specifically in assessing risk in family domestic abuse cases, which will increase the safety of those living with familial domestic abuse and their access to support services. Date Completed: **Norfolk Constabulary** 31/12/2023 **NCC** 31/12/2024

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		adjustment to current process to meet recommendation.		Measure; Composition of group and first meeting by 01/04/24.		

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 6: When services become aware during assessments that a person has habitually used cannabis from their early teens and they develop early onset psychosis symptoms, this should be factored into risk assessments. This is essential in cases of poly-substance misuse co-morbidity to ensure assessments are robust in assessing risk to others as well as risk to self.	Local Multi-Agency	**NSFT** This is a standard within current assessment and risk formulation policy and process. Policy to be updated to include cannabis related psychosis as an example of substance misuse being considered a narrative risk factor in additional to clinical presentation. **Norfolk Constabulary** MASH Domestic Abuse Safeguarding Team to consider referral to Change Grow Live (CGL) in these circumstances. This referral pathway is already considered when addressing the behavioural needs of perpetrators through DAPPA or CARA.. **Norfolk County Council**	**NSFT** Director of nursing, patient safety and safeguarding **Norfolk Constabulary** MASH DI **NCC** Head of ASSD Mental Health .	**NSFT** Substance misuse identified within clinical risk management policy as a risk factor. Policy is updated. Policy update shared. **Norfolk Constabulary** Staff briefed re: Substance Misuse to be considered an additional risk factor and referrals made to CGL in relevant cases. Undertake dip sample after 12 months to understand progress, reporting back to CSP **NCC** To work alongside NSFT in creation of risk assessment.	December 2023 September 2024 September 2024 **Norfolk Constabulary** February 2024 February 2025 **NCC** 01/09/24.	Outcome: Cases of domestic abuse where substance misuse is an additional risk feature is recognised and proactive steps taken to reduce the risk posed to those under threat of abuse, and to divert the alleged abuser into sources of support. Date Completed: **Norfolk Constabulary** **NCC** 1/9/24

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		To work with the NHS (NSFT) and how mental health risk assessments and policy changes to include recommendation (6).		Measure: confirmation of first meeting.		

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 7: All services involved in providing care and/or advice to vulnerable adults should include in their home safety advice the promotion of the County Council's assistive technology equipment which includes the services of the telephone call centre back-up for emergencies when a family member or carer cannot be contacted. This information must always be included where a pendant alarm is recommended or provided. This practice should become routine by June 2023.	Local Multi-Agency	**NSFT** Communication out to all practitioners. **Age UK Norwich** Age UK Norwich staff providing advice to vulnerable adults will be reminded of the County Council's Assistive Technology Equipment available, including the telephone call centre back-up. This information will also be included in our automated responses via our chatbot called 'Vera'.	**NSFT** Assoc Director of patient safety and safeguarding. **Age UK Norwich** Chief Officer	**NSFT** Comms sent out. **Age UK Norwich** Staff briefings to take place at team meetings – completed. Amendments made to chatbot 'Vera'.	January 2024 **Age UK Norwich** 31st March 2024 31st March 2024	Outcome: All those with vulnerabilities or additional needs are in possession of information on the most up to date assistive technologies with built in back up facilities and procedures to ensure their living arrangements are as safe as possible to enable them to live safely and independently in their own homes. Date Completed: **NSFT** January 2024 **Age UK Norwich** 31st March 2024

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		NB Age UK Norwich doesn't recommend one pendant alarm service over another but will give a selection of options available. This will include the County Council's offer above. **Norfolk County Council** Re-examine all ASSD advice regarding assistive technology and advise/make change/s. Most home alarms are provided via District Councils and will be made aware of (7)	**NCC** Director of Commissioning - ASC/ District Councils	**NCC** Undertake examination of website advice and information. Changes to be added as required as per recommendation. Measure: change to website completed.	**NCC** 01/09/24.	**NCC** 1/9/24

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 8: Websites including the Norfolk County Council assisted technology site, the Fire & Rescue Service home safety site, and other county websites which give home safety advice, to insert a prominently displayed message, strongly advising that at least two people's phones, tablets or similar devices should be linked to wi-fi enabled smoke and carbon monoxide alarms to ensure fire alerts can always be received and acted upon immediately. Changes to websites should be in place by September 2023.	Local Multi-Agency	**Norfolk Fire & Rescue Service** Liaise with NCC digital platform to amend website with safety information. Write safety narrative for key message. **Norfolk County Council** Change to website to ensure advice as required (8) **Carers Matter** Incorporate wording created by NFRS into Carers Matter Norfolk's website during the website redesign.	**NFRS** Norfolk Fire and Rescue Service Prevention lead **NCC** Web Applications Manager	**NFRS** Website updated with new information. **NCC** Current Carers matter pages Assistive Technology - : Carers Matter Norfolk talk about NCC Assisted Tech and directs for more information here Assistive technology - Norfolk County Council. On this webpage it says "Sensors/detectors that link to a monitoring centre (via your rented community 'pendant' alarm). For example smoke, low temperature, falls, and property exit sensors" The NCC webpage will direct highlight the NFRS page on fire alarms which includes the most up to date advice.	September 2023 **NCC** 01/04/24	Outcome: Website home safety public information is updated to make the public aware that those choosing to use Wi-fi enabled home safety systems need to have two devices linked to the system, thus increasing their home security and reducing risk in the event of fire. Increased safety based on addition of secondary contacts through telecare providers when signals are received. Early detection of fire is essential in all buildings not only domestic dwellings. Date Completed: **Fire & Rescue Service:** 3rd October 2023 **NCC** 1/4/24

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
			NCC Marie Smith	It is important to note that at no point do NCC promote the use of wi-fi enabled smoke or carbon monoxide alarms **Carers Matter** Website is amended to include wording set out.		**Carers Matter:** 1st October 2024

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 9: All statutory, voluntary, or private services' practitioners and carers whose role includes home safety advice and where a service user has or are intending to install privately purchased wi-fi enabled fire alarms, should strongly advise that at least two devices should be linked to the alarms to ensure back-up if one device is unavailable to enable action to be taken immediately an alert is received. Giving this advice should be included in all relevant training for practitioners and carers. This recommendation's message should be circulated and acted upon as soon as possible.	Local Multi-Agency	Distribute as soon as possible a highly visible eye catching 'e-newsletter' to all statutory, voluntary, and private care providers stressing importance that households using privately purchased smoke/carbon monoxide alarms have them linked to a minimum of two different person's devices to ensure alerts can always be received. E-leaflet design to attract attention to ensure it is not overlooked by busy managers and practitioners. Information is included in the training for Norfolk County Council ASC new starters and complete training for Carers Matter Norfolk. **NSFT** Information distributed to Trust practitioners.	**NCSP/ NSAB/ NFRS/ NCC** Community Safety Manager, Norfolk Safeguarding Adults Board Deputy Manager, Head of NFRS - Head of Prevention and Protection, Operational business lead for Carers – ASC Associate Director, Patient Safety and Safeguarding	E-Leaflet distributed electronically to all statutory and voluntary sector services, through NCSP, NSAB, NFRS and NCC relevant mailing lists **NSFT** Communications sent out **ICB**	February 2024 TBC **NSFT** January 2024	Outcome: Public made aware that those choosing to use Wi-fi enabled home safety systems need to have two devices linked to the system, thus increasing their home security and reducing risk in the event of fire. Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		ICB Fire Safety leaflet disseminated		Fire Safety leaflet disseminated. ICB attended Fire Safety Seminar June 2023 Supported the production of a 7 min briefing with attached resources from Norfolk Fire & Rescue Service. Shared throughout agencies. ICB are now members of fatal fire reviews.	**ICB** **June 24** **June 23**	

LOCAL, SINGLE-AGENCY RECOMMENDATIONS

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 10: To ensure reported improvements in offering carers assessments described to the DHR panel is maintained, an annual audit of carer assessments offered, carer assessments taken up, and outcome of the support should be undertaken and reported annually to the Director of Social Care and Adult Safeguarding Board.	Local	Yearly government returns are available to ensure carer assessments continue to rise and are among a suite of performance indicators available to the Safeguarding Board.	**Adult Social Care** Director of Commissioning - ASC/ Integrated Health and Social Care Director – ASC / Head of Safeguarding, Community Director of Social Work - ASC.	Carers assessments are a key governmental return for ASSD and are monitored closely by internal and external bodies. Safeguarding Board have a selection of such performance data which this will be added to..	01/04/24.	Outcome: Those in a caring role are routinely offered a carer's assessment in accordance with the Care Act to ensure they are all offered the opportunity to receive the support they need in their caring role. Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 11: That the Approved Mental Health Professionals report (AMHP) template to be updated to improve visibility and clarity of the risk assessment section with the aim of making this vital information plainly visible to clinicians throughout the patients journey in Mental Health Services both in hospital and community based.	Local	Approved Mental Health Professionals consult & work in tandem with NSFT & other mental health/learning disability/autism NHS trusts to ensure AMHP forms link into Mental Health Act admissions to inpatient facilities & associated care plans. Changes will occur to ensure inpatient facilities are aware of risks pertinent to Mental Health Act detention as per Code of Practice. The vulnerability of occupants in the household e.g. elder persons or those with learning or cognitive impairment is considered and expressly noted in the risk assessment to ensure that this information is available to all interested parties, particularly at the point of discharge planning.	**Adult Social Care With NSFT** Head of Safeguarding - ASC / Head of ASSD Mental Health – ASC / & NSFT Patient Safety .	Changes to the AMHP form in conjunction with NSFT and within the Code of Practice MHA. Measure: Changes are agreed by NSFT/AMHP Service regarding inpatient admission MHA pathway.	01/03/24	Outcome: Both risk to the service user and risk to others including their family or carer are separately and thoroughly assessed, recorded separately, and risk is noted and updated when situations change. Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 12: Mental Health Service contingency plans should take a 'Think Family' approach and be shared with related parties/carers having been written in plain English and avoiding professional jargon to ensure it is accessible to enable families and/or carers to fully understand the steps to take when required. This should include relevant contacts and phone numbers, and guidance on information required when reporting serious concerns.	Local	"Think family" is to be embedded within assessment and risk formulation. Contingency plans suitably designed for family/carers including information set out in recommendation.	**Norfolk & Suffolk Foundation NHS Trust (NSFT)** Christine Hobdy Associate Director of patient safety and safeguarding	Change project to run as a pilot in child and family services initially; to include genogram app, inclusion in mandatory training for all practitioners, amendments to templates as required including letters and correspondence with families, carers and other interested parties. Communication to staff will commence after pilot. A SOP will be developed as the pilot progresses Genogram app use is being audited through MEG audits. Letters and templates to be audited Friends and family test will be used to measure impact of the Think Family	April 2024 October 2024 December 2024	Outcome: Contingency plans consider family context of service users and within contingency plans, and family or carers have copies of contingency plans for their information. Date Completed: .
Recommendation 13: The Early Intervention Team should confirm back after any meetings with the next of kin in a quick memo (email or letter) any important key information discussed by both sides.	Local	Communication to all practitioners to remind them of best practice in record keeping and communication with service users, carers and other interested parties.	**NSFT** Associate Director of patient safety and safeguarding	Discuss with business change if a template can be added to assist with this action on the electronic patient record. Should extend to all teams not just EIT.	April 2024	Outcome: Service users, carers and affected others will be informed and understand actions and outcomes of meetings with professionals.

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
				Review of current policy in respect of communication with service users. Audit of standard once added to policy and process (6mths post implementation).	October 2024	Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 14: That Norfolk Constabulary examine its policy on risk assessment in cases of familial domestic abuse incidents to ensure the focus on the alleged victim/complainant is not lost, and officers are supported in their professional judgement in risk assessing such cases.	Local	Review and amendment of Norfolk Police Policy	**Norfolk Constabulary** MASH DA Inspector	Policy examined, reviewed and amended in September 2023 to include Adults at risk of harm and to highlight DARA risk assessment alongside professional judgement for initial attending officers.	December 2023	Outcome: Norfolk Constabulary policy gives guidance on risk assessment and use of professional curiosity to ensure that the first priority on attendance is to protect victims and any other persons at risk within the address. Date Completed:11/10/2023
Recommendation 15: Local Authority Housing Departments when making enquiries to establish the status of a homeless applicant claiming to have been excluded from home, should ensure that the person said to have excluded them, and/or the accommodation owner should be spoken to independently to confirm whether they freely agree for the applicate to return, or to confirm they are excluding them.	Local	District Council Safeguarding leads to challenge their housing staff to incorporate recommendation into policy and practice District Council Safeguarding leads to report to District Council Safeguarding Group on progress	Broadland and South Norfolk District Council as chair of District Council Safeguarding Group	Housing staff tasked – December 2023 Safeguarding leads report back – February 2023		Outcome: Staff ensure that an accommodation owner is spoken to independently to establish the veracity of a claim that a person is excluded from their property or that they may return to confirm their opinions are their own and no coercion is evident. Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 16: The University Counselling and Mental Health Service should examine its threshold for deciding when the enhanced welfare check and assessing a student in person is used and ensure decision making is informed by information from all support services, and academic departments involved in the student's University life, plus external sources who have provided information such as family or guardians if relevant and appropriate.	Local	Undertake a review of the threshold/criteria at which an enhanced welfare will be undertaken (or a visit requested by a third party such as the Police). This will be led by the Head of Service and the Director of Campus Life. Any changes to be written into relevant protocols and all staff to be briefed on the changes.	**University of Manchester** Director for the Student Experience,.	Initial review discussion has been completed by the Head of Service and the Director of Campus Life, with input from some of the service's staff. Further discussion to agree any changes to protocols planned.	30th September 2023	Outcome: Complex cases, by their nature, are such that it is impossible to codify a threshold for every eventuality. However, all staff in the Counselling and Mental Health Service have been reminded that an enhanced welfare check is an option they can consider. The use of existing escalation pathways to request such a check has been made more explicit. Completed: 30 September 2023
Individual Agency Recommendations from IMRs						
Recommendation 17: Whilst work has been done in SCCE about carers, and to remind adult social care staff to be reminded of the importance of identifying carers and providing information and referring to Carers Matters Norfolk for a carers assessment, it is recommended that ASSD	Local	Continuation of ongoing work in SCCE and resulting increased numbers of carers being offered assessments and advice and guidance.	**Adult Social Care** Head of Safeguarding, Community Director of Social Work - ASC	Carers assessments are a key governmental return for ASSD. Ongoing monitoring to ensure the trend line is upwards for SCEE. Measure: trend line increase.	01/04/24	Outcome: Carers are identified and offered a carer's assessment to which they are entitled under the Care Act and this is monitored to ensure staff are fulfilling this duty. Date Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
has an increased focus on carers and the need to identify carers and refer for a carers assessment or provide information.			Assistant Director			

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 18: That there is a presentation to the AMHP forum about learning from the IMR to include verbally handing over safeguarding concerns for others in the patients home when a person is admitted to hospital and recording this on LAS.	Local	Presentation to AMHP Forum on DHR recommendations and examination how AMHP MHA forms are updated into LAS as currently are updated into NSFT system.	**Adult Social Care** Head of Safeguarding, Community Director of Social Work - ASC Assistant Director	To link DHR changes to the AMHP form and DHR recommendation by ongoing discussion to AMHP professional forum. LAS recording examination and linkage to NSFT records via Shared Care record development.	01/03/24	Outcome: AMHP handover to Mental Health colleagues includes information on vulnerable persons or those in need of safeguarding within the service user's home to ensure this information is considered in discharge assessments to increase their wellbeing and safety. Date Completed:
Recommendation 19 : The trust will explore the possibility of additional scenario-based training in respect of mental capacity and application of the Act.	Local	Roll out of scenario-based training by MCA lead and team.	**NSFT** MCA Lead	Evidence of training outline and attendance. Audit of MCA practice against policy standards (6mths post training implementation)	April 2024	Outcome: Feedback from practitioners will show an improved understanding of the application of the MCA. Assurance activity will demonstrate an improved application of the MCA, leading to better outcomes for service users. Date Completed:
Recommendation 20: The trust will ensure that the mandatory domestic abuse, and safety planning and risk		Mandatory training to be reviewed against this action.	**NSFT** Associate Director of	Review outcome to be communicated through NCSP Training Standards Checklist		Outcome: Mandatory domestic abuse training for staff equips them to assess risk to all the

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
assessment training addresses assessment of risk relevant to all parties living within a household.	Local	NSFT to provide a NCSP Training Standards implementation Checklist return and work with the partnership.	patient safety and safeguarding	NSFT fully meets NCSP training standards.	October 2023	household of a service user and identify risk of and posed by domestic abuse. Completed: October 2023

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendations 21: The panel concluded that contingency planning should have been more robust with additional information related to this shared with the family. Contingency planning within care plans should also be shared as required with involved services and related parties/carers.	Local	Audit to be undertaken of contingency planning being undertaken and shared.	**NSFT** Internal Audit Lead	Audit undertaken on 08.04.22 – compliance 92%. Audit ongoing to monitor compliance.	April 2022 2022-23	Outcome; Affected others and service users know what care and treatment they can expect to receive, what to do in a crisis and what other avenues of support are available to them. Date Completed: April 2022 & ongoing monitoring
Recommendation 22: That the Mental Health Trusts roll-out of DIALOG and DIALOG+ system be maintained and reviewed, and in due course audited to ensure social, cultural, familial, and other patient - based information can be built into care in Norfolk more effectively.	Local	Roll out of DIALOG + continues across the Trust to encourage professional curiosity and ensure detailed information recorded effectively to inform support plans.	**NSFT** Trust wide CPA/DIALOG+ lead	Annual audit of system to ensure quality of information for assessments commence. Monthly audits undertaken as part of a rolling programme.	April 2022	Outcome: Holistic assessment of service users, providing social, economic, health and welfare information will lead to better outcomes which are measurable. Date Completed: April 2020 & ongoing monitoring.

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 23: Contingency planning within care plans should also be shared as required with involved services and related parties/carers.	Local	As per recommendation 25 i.e. Audit undertaken of contingency planning being undertaken and shared with related parties/ carers.	**NSFT** Internal Audit Lead	Audit undertaken on 08.04.22 – compliance 92%. Audit will be ongoing to monitor compliance.	April 2022	Outcome: Contingency plans are routinely shared with involved services, service users and their related parties or carers to keep them fully informed of any steps needed to be taken. Date Completed:. April 2022 & ongoing monitoring
Recommendation 24: The Trust will strengthen arrangements for assessments of safeguarding and teams (in team meetings and in supervision) should strengthen the way that they engage with families to maintain their professional curiosity about the wider impact in families. The clinical team should reinforce their policy for `Think Family'.	Local	As in recommendation 12 the Think Family approach will be embedded in practice to strengthen assessments and engagement with family/carers. Supervising managers to ensure practitioners fully consider the impact on service users families and/or carers in their casework and offer or direct them to support.	**NSFT** Associate Director of patient safety & safeguarding	Change project to run as a pilot in child & family services initially; to include genogram app, inclusion in mandatory training for all practitioners, amendments to templates as required including letters & correspondence with families, carers & other interested parties. Communication strategy to staff implemented. Audit against policy standards (6-12mths post implementation)	April 2024 April 2024 October 2024	Outcome: Practitioners fully aware of service user's family members and/or carers and the impact on them of the service user's mental health is considered in contingency plans and mitigated as far as possible. Date Completed:
Recommendation 26: Norfolk and Waveney ICB to launch a template Domestic Abuse policy for	Local	Template policy will be created by the Safeguarding Adult team in Norfolk & Waveney ICB with input from	**Adults Norfolk & Waveney**	Daft template policy shared with Norfolk Local Medical Committee in 2022 for review & comments.		Outcome: All GP practices have a domestic abuse policy in place and greater awareness of

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
all GP practices in Norfolk and Waveney to be shared in 2022.		the ICB designated Safeguarding Children's team & colleagues from Norfolk Community Safety Partnership. Template policy to include types of domestic abuse including abuse of older people; role of Domestic Abuse practice champion; best practice guidance on assessment & responding to domestic abuse & how to protect staff who may be experiencing DA. Colleagues consulted & encouraged to discuss the policy in their safeguarding practice meeting & adapt the document to meet the needs of the practice.	**Integrated Care Board** Named GP for Safeguarding	Final version shared with all GP practices in Norfolk & Waveney in May 2022. Added to Knowledge Anglia website a resource for GP practice staff in Norfolk & Waveney. In May 2022 GP practices in Norfolk & Waveney were asked to consider signing up to the HEAR campaign. This Norfolk wide campaign calls on employers to break the silence & provide support to their staff on DA. Template policy reviewed & updated in May 2023 in response to learning from DHRs & shared with all GP practices in Norfolk and Waveney. Feedback form shared in October 2023 to gather feedback from general practices..	May 2022 May 2023	domestic abuse and the role of the practitioner identifying and responding to domestic abuse is increased resulting in patients or staff experiencing domestic abuse being more effectively and appropriately supported. Completed: May 2023

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome

Recommendation 27: Norfolk and Waveney ICB to relaunch a revised policy template for Safeguarding Adults for all GP practices in Norfolk and Waveney to be shared in 2022. This to include a case-based scenario which covers assessment under the Mental Capacity Act (2005) and Autistic spectrum disorder in future Safeguarding Adult Level 3 teaching for primary care colleagues	Local	Template policy will be created by the Safeguarding Adult team in Norfolk and Waveney ICB with input from the Norfolk Safeguarding Adults Board. A case scenario covering Mental Capacity Act (2005) and autistic spectrum condition was developed in 2021 to be included in Level 3 Joint adult and children Safeguarding training delivered by Norfolk and Waveney Integrated Care Board. Template includes legislation, policies, guidance, and Care Quality Commission Key Lines of Enquiry relevant to safeguarding adults. Also includes guidance on making safeguarding personal, professional curiosity, mental capacity Act, lasting power of attorney and reporting safeguarding concerns all relevant to this DHR.	**Norfolk & Waveney Integrated Care Board** Named GP for Safeguarding Adults & Safeguarding Adult Lead Nurse, producing template Safeguarding Adult template policy for general practice. Named GP for Safeguarding Adults developed the case based scenario for training.	Case based scenario developed in 2021 for the monthly joint safeguarding training refresher session for colleagues adapted for use in Safeguarding Adult Level 3 core training sessions delivered by the ICB twice a year. Draft template policy was shared with Norfolk Local Medical Committee in 2022 for review and comments. The final version was shared with all GP practices in Norfolk and Waveney in May 2022. It was also added to the Knowledge Anglia website which is a resource for GP practice staff in Norfolk and Waveney. The template policy reviewed and updated May 2023 and shared again. Template policy shared with GP practices May 2023 via Spotlight on Safeguarding Newsletter. A feedback form was shared with practices in October 2023. The impact of the learning is measured through colleague feedback in a feedback questionnaire shared after the training sessions.	2021 2022 May 2022 May 2023 May 2023 October 2023	Outcome: Increased knowledge, awareness, and case based scenario supports colleagues to apply professional curiosity, exploration of mental capacity, and identify safeguarding issues where support or protection may be required for vulnerable adults. Completed: May 2023

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 28: A message should be included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter to remind staff and raise awareness to be professionally curious when having discussions with patients about clutter and hoarding. It should be borne in mind that even after the environment being cleared and made 'safe' it is important to understand the triggers and root causes (if able) so that warning signs can be picked up as early as possible by both the patient and staff, and support strategies can be offered to the patient. This message should also be shared at each of the local Place Governance and Quality meetings. This should be completed by End October 2022.	Local	Message included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter and shared at each of the local Place Governance and Quality meetings to remind staff and raise awareness to be professionally curious when having discussions with patients about clutter and hoarding. Staff will be reminded of the importance of understanding root cause for hoarding.	**Norfolk Community Health & Care NHS Trust** Mark Rowland	Message created Message included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter Message included as part of the shared at each of the local Place Governance and Quality meeting	October 2022	Outcome: Staff aware and vigilant in identifying hoarding and clutter within homes and able to sensitively address the issue with the aim of increasing home safety and personal wellbeing to prevent accidents in the home. Date Completed: April 2023
Recommendation 29 : A message should be included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter to remind staff and raise awareness to be professionally curious when	Local	Message included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter and shared at each of the local Place Governance and Quality meetings to remind staff and raise awareness to be	**Norfolk Community Health & Care NHS Trust**	Message created Message included as part of the Norfolk Community Health and Care NHS Trust Safeguarding Newsletter	February 2024	Outcome: Staff use professional curiosity to enquire about missed or cancelled appointments to ensure the wellbeing and safety of patients in case they need

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
appointments are repeatedly cancelled/not attended and the source of information for the cancellation is not the patient. Staff should not automatically conclude that there is abuse occurring, but they should explore to ensure there is no controlling behaviour occurring. This message should also be shared at each of the local Place Governance and Quality meetings. This should be completed by end October 2022.		professionally curious when appointments are repeatedly cancelled/not attended and the source of information for the cancellation is not the patient.. Staff will be reminded of the importance of understanding root cause for hoarding.	Deputy for Safeguarding Adults	Message included as part of the shared at each of the local Place Governance and Quality meeting		aid to attend or other barriers to attendance prevent keeping appointments. Date Completed: September 2023
Recommendation 30: A piece of work should take place looking at and considering the development of a risk assessment relating to patients who do not attend appointments, or cancellations are made by people other than the patient themselves or there are safeguarding concerns. This could become part of the Safeguarding Adults Policy. The initial scoping of this risk assessment should be completed by end of July 2022. Any final risk assessment should be completed by the end of October 2022.	Local	Review current Childrens Safeguarding Did Not Attend/Was Not Brought risk assessment to determine if any transferable elements to adults. Develop a Did Not Attend/Was Not Brought risk assessment for Adults. Peer review of risk assessment within Safeguarding Team. Include risk assessment as part of NCHC Safeguarding Adults policy in draft form. Present new risk assessment to Clinical Review Group. Present new Safeguarding Adults Policy including Did Not	**Norfolk Community Health & Care NHS Tust** NCHC Safeguarding Team	Review current Childrens Safeguarding Did Not Attend/Was Not Brought risk assessment completed – July 2023 First draft decision support tool for Adults in clinic and in community setting completed – July 2023	New Policy in place including Did Not Attend/Was Not Brought risk assessment by 31/12/2023	Outcome: Greater awareness by staff of possible implications of patients missing or cancelling a number of appointments and steps taken to determine reasons and the wellbeing of patients checked and safeguarded if required. Completed:

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
		Attend/Was Not Brought risk assessment for Adults to NCHC Policy Review Group for ratification/sign off. Trust wide communication				

RECOMMENDATION	Scope of recommend-ation	Action to be taken	Lead Agency	Key milestones	Target Date	Date of completion and Outcome
IMR Recommendation 31 Where concerns are raised about a student's behaviour and/or mental wellbeing, information should be gathered from all relevant pastoral, health support, and academic sources to inform a support plan. This should include the student's tutor who will have an up to date picture of their attendance and progress.	Local	Recommendation needs to be written into a protocol and then relevant teams briefed and given guidance on its use to ensure it is enacted.	**The University of Manchester.** Director for the Student Experience,	Discussion held with heads of service in the Division of Campus Life. Next step is to codify into a full procedure and enact.	30th September 2023	Outcome: Updated approach is now embedded in practice and Campus Life hold the responsibility for drawing together and assessing the full background information on a student of concern. Completed: 30th September 2023.
IMR Recommendation 32 To bring clarity for staff regarding information sharing	Local	Develop and implement a formal protocol around steps to be taken when	**The University of Manchester**.	Initial discussion undertaken, protocol developed		Outcome: This is now in place and has been communicated to relevant staff.

procedures when a family member raises concerns for the health and wellbeing of a student, but it is judged the circumstances do not meet the criteria for sharing person information, the family member should routinely receive a follow-up phone call or email within 2 working days to confirm what actions were being taken. There will be very rare cases where this may be judged inappropriate (e.g. if the University is already aware that the student is estranged from their family) in which case this should be recorded.		receiving concerns from a family member of another third party.	Director for the Student Experience,	and dissemination to relevant staff.	30th September 2023	The Director of Campus Life will check a small number of sample cases in 6 months' time to ensure it is being followed. Completed: 30th September 2023

RECOMMENDATION	Scope of recommend-ation	Action to be taken	Lead Agency	Key milestones	Target Date	Date of completion and Outcome
IMR Recommendation 33 When a family member has raised concerns about a student's wellbeing, notes of the information given by the family member and their concerns should be recorded, placed on the student's file, and a summary of their concerns emailed to the family member to ensure	Local	New protocol required to ensure that staff receiving a first contact from a family members record their concerns and email them a summary to ensure it is an accurate and complete representation. This is for School Student Support and Wellbeing teams and	**The University of Manchester.** Director for the Student Experience,	Agreement already reached with Campus Life teams (e.g. Advice and Response and Counselling and Mental Health Service to introduce this change). Approach now needs to be widened to the	1st December 2024	Outcome: When a family member has raised concerns about a student's wellbeing, notes of the information given by the family member and their concerns should be recorded, placed on the student's file, and a summary of their concerns emailed to the family member to ensure the

the summary is an accurate representation of the concerns.		Campus Life Teams (particularly Advice and Response)		academic schools head of the next academic year.		summary is an accurate representation of the concerns". Completed:
IMR Recommendation 34: Family members contacting the University with concerns about a student should have explained to them the limitations for sharing personal information about the student, when information can be shared, and the duties this places on the University's ability to provide detailed feedback. The University should consider producing a pdf leaflet explaining their information sharing policy which can be emailed to family members to enable them to digest and understand the policy in their own time. Also explain what exceptions are available in case the family members believes that some of the criteria have been met, so they can ask for the decision to be reconsidered.	Local	Review of information available to parents and other third parties was undertaken, including considering different points of contacting the University via the internet and telephone. Work included input from those outside of the student support area. Additions made November 2023 to recommendation by family member re: exceptions available when information can be shared, accepted by Panel.	**The University of Manchester**. Director for the Student Experience,	There is now a summary section on the University's pages about raising concern (https://www.studentsupport.manchester.ac.uk/taking-care/student-enquiries/) with a clear link to the PDF outlining limitations (the same document that is also shared with students) https://documents.manchester.ac.uk/display.aspx?DocID=50263 Additions to recommendation implemented with staff.	Already completed July 2023 January 2024	Outcome: This is now in place and has been communicated to relevant staff. The Director of Campus Life will check a small number of sample cases in 6 months' time to ensure it is being followed. Completed:

RECOMMENDATION	Scope of recommend-ation	Action to be taken	Lead Agency	Key milestones	Target Date	Date of completion and Outcome
IMR Recommendation 35:	Local	Conduct a review of the information available to		. A single, easily traced and navigated pathway to		Outcome:

That the University reviews the existing information provided on its website to ensure that there is a single, easily traced and navigated pathway to make contact with concerns about a student 24 hours a day and that there is clarity about what anyone raising concerns can expect in terms of next steps.		parents and third parties on the University's website to ensure it is accurate, consistent and on a single page. The information must ensure there is clarity about how to raise concerns about a student 24/7.	**The University of Manchester.** Director for the Student Experience,	make contact with the university regarding concerns about a student 24 hours a day in place.	Already completed (July 2023)	Pathway to contact the university regarding concerns about a student 24 hours a day now published on University's website. Also provides clarity about what next steps can be expected. https://www.manchester.ac.uk/connect/contact-us/enquiries-or-concerns-about-students/ Completed: July 2023
Recommendation 36: Non-intimate domestic abuse involving an Adult at Risk of Harm to be included in ongoing training events which are conducted yearly with all officers. This training should highlight professional curiosity and encourage officers to check on vulnerable adults within a domestic environment even when they are not the victim of the offence.	Local	Review existing Domestic Abuse training given to all officers. Develop a revised training package including a scenario with an adult at risk of harm present in the address who is not the victim	**Norfolk Constabulary** Safeguarding Development Inspector	Training reviewed and revised. New scenario included and all domestic abuse training amended from October 2023 onwards. All Norfolk Constabulary officers now receiving the new training	July 2023 31 October 2023	Outcome: Improved awareness of familial abuse, vulnerable persons within addresses, and increased professional curiosity – this is tested/measured at the conclusion of the training and outcome of risk assessments. Date completed: 31/10/2023
Recommendation 37: Non-Crime Adult Protection Investigations with an associated risk assessment should be completed at any domestic abuse incident where an Adult at Risk of Harm is present as well as when they are a victim.	Local	Force Policy to be amended. Officers to be made aware of and enact the change. Multi agency safeguarding hub to monitor submission of API's	**Norfolk Constabulary** MASH DA Inspector	Policy amended in September 2023 (MASH DA Manager) monitoring as at 27th September 2023 Force policy change to be highlighted to officers in	Sept 2023 Sept 2023	Outcome: Improved monitoring, oversight and provision of feedback on risk at daily senior management meeting With the aim of identifying victims at risk of harm and actions to increase their safety.

				briefings and communications.	October 2023	Date completed: 11/10/2023

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target Date	Date of completion and Outcome
Recommendation 38: The Norfolk Multi-Agency Safeguarding Hub will review any domestic abuse related Non-Crime Adult Protection Investigation and consider information sharing with partner agencies where Adults at Risk of Harm are present but not given victim status.	Local	All "Non crime Adult Protection Investigations" (API's) to be risk assessed and shared with partner agencies where they highlight concerns for vulnerable adults	**Norfolk Constabulary** MASH DA Inspector	As a result of the policy change all API's submitted since 11th October 2023 are risk assessed and shared with partner agencies where there are concerns for a vulnerable adult present in an address		Outcome: Improved information sharing between partner agencies and awareness of risk relating to adults at risk of harm Measure through feedback from partner agencies Date of completion: 11/10/2023