DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Into the death of Sofia

in

December 2020

Report Author

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

Date 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 every family member’s expectations.

Nothing can diminish those 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

Section		Page
1	The Review Process	1
	Contributors to the Review	1
	The Review Panel Members	2
	The Author of the Overview Report	3
	Terms of Reference for the Review	3
2	Summary Chronology	9
3	Key Issues Arising from the Review	17
4	Conclusions	18
5	Lessons Learnt	18
6	Recommendations	24

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

1 The Review Process:

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

1.2 The following pseudonyms have been used in the review for the victim and perpetrator to protect their identities and those of their family. The pseudonyms were chosen by family members:

1.1 The victim Sofia: aged 89 years at the time of her manslaughter. Sofia was of Swedish ethnicity.
The perpetrator Brennan (Sofia's grandson): aged 19 years at the time of the offence. Brennan was of dual heritage Thai/white British ethnicity.

1.3 Criminal proceedings were completed in October 2022 when, following a guilty plea to manslaughter due to diminished responsibility being accepted, the perpetrator was sentenced to a Section 37 Hospital Order with Section 41 Restriction Order[1] under the Mental Health Act 1983.

1.4 The review process began with an initial meeting of the Community Safety Partnership on 13 January 2021, however further meetings were required to achieve agreement that the circumstances met the criteria for a DHR, and after consultation with the Home Office the decision to hold a DHR was confirmed on 7 May 2021. The chair was appointed in August 2021.

1.5 A total of 18 agencies with the potential to have had contact with the victim and or the perpetrator were asked to confirm whether they were involved with them. Twelve agencies confirmed contact with the victim and/or the perpetrator and they were asked to secure their files.

Contributors to the Review

Name of Agency	Chronology	IMR	Report
1.Norfolk Police 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)	√	√	
6.Norfolk Community Health & Care NHS Trust (O.T. Physio)	√	√	
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] A Section 41 Restriction Order requires that the decision about release from a secure hospital is made by the Secretary of State. Any breach of supervision following release can result in the person be recalled into custody. https://so01.tci-thaijo.org/index.php/hbds/article/download/156403/133623

1.6 The authors of agency Individual Management Reviews (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.

1.7 Family and a friend of Sofia's have also contributed to the review.

The Review Panel Members

1.8 The following were members of the DHR Panel for this review:

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 Team
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	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[2]	Norfolk Constabulary	Inspector – Investigations
Gregor Preston	Norfolk Fire & Rescue Services	Head of Prevention, Protection & Emergency Planning
Claire Farrelly[3]	Norfolk Children's Services	Advisor, Safeguarding Education Quality Assurance & Regulation
Louise Honour	Manchester Health and Care Commissioning (for GP Practice)	Designated Nurse for Safeguarding Adults

Panel members were senior members of their organisation and did not have line management responsibilities for staff who had contact with the victim or perpetrator. Nor did Panel members have contact with Sofia or Brennan.

The Author of the Overview Report

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

1.10 Gaynor Mears has extensive experience of working in the domestic abuse field both in practice and strategically, and roles at county and regional levels. She has experience of undertaking Domestic Homicide Reviews from their implementation in 2011, and research and evaluations of domestic violence services. Gaynor Mears has experience of working in crime reduction as a community safety manager; with Community Safety Partnerships; and across a wide variety of agencies, both in the statutory and voluntary sector. She has also served as a trustee of a charity delivering a Respect accredited community perpetrator programme. Gaynor Mears meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of the experience required for the role and her training which she regularly updates. She has no previous connections with any agency in Norfolk other than as a previous chair and author of DHRs for the Norfolk County Community Safety Partnership the last of which was completed in 2020.

1.11 Terms of Reference for the Review

The purpose of the Review is to:

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

[2] 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.

[3] 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.

- 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.

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[4] (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.

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)?

[4] 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.

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[5] 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.

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.

[5] 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.

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?

2. Summary Chronology:

2.1 Sofia lived in her own home of almost 60 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 was retired from a long and successful academic career and she was a respected author in her specialist field. She came to the United Kingdom 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 younger sons lived elsewhere in England.

2.2 Sofia was very independent and it is clear from assessments that her overriding wish was to stay living in her own home; she did not want to be in residential care. In April 2017 Sofia completed a 'Do Not Attempt Resuscitation' form which was recorded in her medical notes; her notes state "patient very clear about it". Earlier in 2009 Sofia's GP was made aware that Lasting Power of Attorney had been put in place with her daughter and solicitor made Attorneys. Sofia had a number of health conditions for which she was prescribed medication, and in 2017 a scan identified age related mild short term memory changes.

2.3 Sofia had become less mobile since a fall in 2019 in which she sustained a broken arm. Following a period of recuperation with her daughter, Sofia returned to her own home with her eldest son moving in to care for her along with time limited visits from First Response[6] carers. There was also a period of weeks when live in carers were engaged to support Sofia's recovery and when her son had prearranged work commitments abroad. Although affected by age related frailty Sofia's mobility gradually improved and carers were no longer commissioned unless Sofia's eldest son had to travel abroad. Daily carer visits took place at such times.

2.4 The perpetrator Brennan, the son of Sofia's eldest son from his first marriage, came to the United Kingdom aged 15yrs from Thailand in 2017 to complete his education. Brennan's father had arranged for his son to study A levels at a state boarding school while he was away working abroad. The school listed Sofia as Brennan's guardian. School communication with Brennan's parents was via email whilst he was at the school.

2.5 Brennan and Sofia had not had direct contact since he was a very small child. As a result of geographical distance and the passing years they were unfamiliar with each other. Brennan stayed at Sofia's home a few times during the first two terms at school, however during a second term stay Sofia went to her daughter's home in a distressed state due to Brennan's behaviour; she said he was smoking, blowing smoke at her and opening windows. Brennan's father was contacted to deal with the situation, and it is understood that Brennan would not stay with Sofia in future. During the remaining time at school his mother arranged bed & breakfast (B&B) accommodation for Brennan via the internet. He spent the summer holidays in Thailand. During his last term at school Brennan was found using a testosterone supplement which was unsuitable for his age, and although academically successful, his attendance at classes reduced and he was also caught smoking. His parents were informed and he was banned from boarding. He left the school in June 2019 and returned to Thailand for the summer. In September 2019 he returned to the UK and went straight to Reading University to commence a degree.

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

2.6 In June 2019 Sofia's youngest son emailed a letter to Adult Social Care outlining safeguarding concerns about his mother's care. The letter alleged Sofia made scripted video messages, 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, and family members felt discouraged or stopped from visiting their mother. On the same day Sofia's daughter raised similar issues with Sofia's GP who identified the information as a safeguarding concern and offered to contact Social Services. This was recorded by the GP as declined as Sofia's daughter was aware of the letter already sent to Adult Social Care.

2.7 The safeguarding concern referral was dealt with by an assistant practitioner with management supervision and discussion with a Safeguarding Adults practice consultant in the MASH[7]. Sofia's youngest son was asked to obtain her views and whether she wished Social Services involvement, this he did in a phone call to Sofia. Sofia's youngest son wanted a home visit to be made, but he was informed this was not within the Service's policy. A carer's assessment could be offered if Sofia's eldest son wished. Sofia declined Social Services involvement and she was deemed by the Service to have mental capacity to make that decision. No further enquiries were made by the Service made the decision that there was no role for Social Services or Safeguarding at this time. Sofia's eldest son (Brennan's father) who was providing her care strongly refuted all the allegations made in the referral when he became aware of them, including that at no time did he prevent or forbid his siblings from visiting Sofia.

2.8 In April 2020 Brennan left Reading University and came to stay in his grandmother Sofia '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. It was during this break that Brennan decided to change degree and he applied for course in Artificial Intelligence at the University of Manchester.

2.9 During the evening of 30 May 2020 Brennan made a series of incoherent 999 calls to the Police alleging that he could hear screaming noises from next door. This was followed by a call from the neighbour reporting that they had opened the door and Brennan had tried to push past; no injury was caused, and Brennan had left. The neighbour spoke with Brennan's father and became 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. When officers attended the house was in darkness, therefore a visit was made next morning. When this took place, it was clear to officers that Brennan was mentally unwell and paranoid and they called the mental health Crisis Team. Officers left but were called back 40 minutes later as Brennan had become aggressive, assaulted his father, and had a 'verbal incident' directed towards his grandmother Sofia.

2.10 Brennan was assessed as needing treatment under Section 2 of the Mental Health Act, and due to a lack of NHS beds, he was admitted to a private hospital in the county. The Approved Mental Health Professional Report completed for the assessment captured information from Brennan's father that Brennan had been admitted to a facility in Thailand for gaming addiction, and he had shot his mother with a BB pellet gun which required her to have hospital treatment. He had also caused considerable damage to his mother's apartment including cutting up her clothes. The report included 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'[8]. 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

[7] Multi-Agency Safeguarding Hub

[8] Brennan's father reported to the chair that Brennan spoke 'American English' including slang terms which his mother did not understand.

reaction was is not recorded). The report noted Brennan did not want to return home and his grandmother was said to be anxious and scared of him.

2.11 Brennan himself stated he felt mentally unwell. Initially he said he had been drinking lager, using methadone, and injecting heroin; however, screening later showed no evidence of these substances. Brennan's father appeared unaware of any drug use by his son. Later in the assessment with Brennan it was noted he 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.

2.12 Brennan's 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' due to the altercation with his father. With supervision to ensure he took his medication Brennan's symptoms improved very quickly. His father is noted as attending a ward meeting with staff.

2.13 A discharge meeting took place on 18 June 2020. This was planned at a time to ensure Brennan's father was at home, and partially held online due to Covid restrictions. No risk to others nor the assessment's comments that Sofia was scared of Brennan were noted during the process. Brennan was transferred to the care of a community consultant psychiatrist and care coordinator in the Mental Health Trust Early Intervention Team[9], He was prescribed anti-psychotic medication Risperidone and Lorazepam 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 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.

2.14 Brennan was followed up by phone on 9 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. He was then seen in person on his own at Sofia's home on 24 June. 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 'odd thoughts'. Brennan's father was then spoken to and briefly outlined Brennan's childhood in Thailand and past mental health. Sofia was not spoken to. An outpatient appointment was booked with a consultant for 1 July.

2.15 Brennan phoned the Early Intervention Team on 29 June 2020 and was invited to the Trust site. 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 felt isolated from his mother in Thailand; he said he needed help networking and finding things

[9] 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.

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 the following day which he did. 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 reported he had removed some of the items from Brennan's room. During the review no psychotic symptoms were reported or observed. The Risperidone prescription was amended to 3mg.

2.16 On 2 July 2020 at 19.57hrs Brennan's father called the Police to report Brennan had run away from home following an argument with his grandmother about him smoking (recorded by Police as Brennan smoking 'weed' in records of the call reporting him missing by father). He was concern for Brennan's safety due to his recent hospital admission. Brennan was located and a welfare check made by officers to a hotel where he was staying; he said his grandmother did not want him there anymore. Officers received information from the mental health nurses based within the Police Control Room which confirmed Brennan was open to the Early Intervention Team. There was no history of self-harm or suicide, and Brennan told the Police he had no intention of self-harm. He said there were issues at home and he was made to feel unwelcome; he left to give himself some space. He had funds from his mother to stay at the hotel for a month.

2.17 The following day, 3 July 2020 Brennan phoned the local authority Housing Department Homelessness Team saying he was homeless. How Brennan knew he could do this is not known. Enquiries were made by phoning Sofia's home. Brennan's father answered explaining he was his mother's carer and she did not remember what she had said to Brennan; she was not aware of the consequences of her decisions. Brennan's father said he had spoken to his mother and Brennan could return home. Sofia herself was not spoken to. Brennan was advised he could return to his grandmother's but he chose to remain in B & B accommodation.

2.18 Brennan attended an arranged appointment at the Early Intervention Team on 15 July 2020. He denied having an argument with his father before moving out of his grandmother's home. 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 in Thailand and she had agreed to fund B & B until university started in September. Brennan said he got on well with the B & B owner; they watch television together and played chess, he was feeling well and had not experienced any symptoms of mental ill-health.

2.19 Brennan attended an appointment on 29 July 2020 which included a medication review. He denied any feelings of aggression or thoughts of harm to himself or others. His care coordinator sought his consent to contact student support at 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 regarding his earlier admission for treatment in Thailand, but there were no records. The plan; Medication was reduced to 2 mg Risperidone and a further appointment made for 26 August. This appointment was missed. Brennan was informed by phone that an application for disabled student allowance had been sent to the home address with supporting documents. He confirmed he was aware of his medication and he was taking it.

2.20 A further medical/joint meeting was planned for 16 September 2020. A physical health appointment on 2 September was cancelled by Brennan and he did not attend the meeting on 16 September. After being texted a reminder, Brennan contacted his care coordinator to say he was catching a train to Manchester to start his degree. He said he was still compliant with medication and had collected a prescription from his GP prior to leaving. The consultant raised concerns about poor medication compliance as his last prescription was collected from Mental Health Services on 29 July 2020. Brennan never did collect

his medication from the GP. Despite encouragement Brennan refused consent to enable the Trust to contact or make referrals to student support or the Early Intervention Services in Manchester. Brennan agreed to the care coordinator calling him in a week.

2.21 Brennan registered with a Manchester GP practice, but due to Covid NHS Guidance he was not seen for a new patient review. Brennan informed the Early Intervention Team care coordinator of his GP and a letter was sent outlining his treatment plan with a request to refer him to mental health services if he became unwell. The GP practice logged a review to take place in Spring 2021. Although Brennan was now in Manchester the Norfolk Early Intervention Team decided to keep his case open in case he returned to their area. This was good practice.

2.22 On 16 November 2020 the student support system within halls of residence[10] was triggered when one of Brennan's flatmates emailed a support advisor seeking advice as they were worried and a bit scared by Brennan. He isolated himself in his room only coming out to eat, had been caught taking other students food, he would bang on the wall of his room keeping them awake at night, and he was getting drunk regularly. They were aware from Brennan that he had had mental health problems and had been Sectioned once. The atmosphere in the flats had deteriorated.

2.23 The advisor visited Brennan the following day with a colleague. He was agitated and paced up and down the corridor. Conversation was difficult as he would not engage; he was adamant that everything was alright. The only things raised by Brennan were family issues; that he did not have a good relationship with his father, he had financial issues, and was thinking 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 given information about other sources of support. A second visit took place the next day, but Brennan was uncommunicative and wanted the advisors to leave. He was very dismissive, denied there were any issues, saying he was either too drunk to know what happened or there was no problem in the first place. After discussion with their manager, it was agreed to give Brennan the opportunity to show he would not repeat the behaviours causing the complaint and to remain in contact with him.

2.24 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 to express his concerns to the university's student support. 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.

2.25 On 19 November 2020 Brennan's father phoned the university expressing concerns about his son and the switchboard operator emailed the duty officer in the Counselling and Mental Health Service to see if Brennan was known to them. 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. A team member contacted the advisors who outlined their involvement with Brennan.

[10] 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).

2.26 On 20 November a staff member from the Advice & Response team called Brennan's father and noted his concerns about Brennan's erratic thinking, impulsivity, and that his mother thought 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. He was seeing a counsellor at home but now doesn't have any mental health support. Brennan's father described his recent behaviour as unusual but stated that he did not believe he was at risk to himself or others. He also though Brennan may not be attending classes, Brennan kept calling him for money and was applying for high paid jobs for which he had no qualifications. Brennan's father requested that the university contact Brennan's GP to assess him. This could not take place as the university did not hold details of a student's GPs.

2.27 Following this call, the duty officer (a qualified mental health nurse) in the Counselling and Mental Health Service called Brennan the same day. He managed to speak to Brennan after a couple of attempts, but he was not keen to engage in a discussion and was clear that he did not want any support. No call was made to his tutor to check his progress on his course. On 23 November 2020, the Heads of the Counselling and Mental Health Service and the Advice and Response Team discussed whether 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) and concluded trying to force Brennan's engagement with support was counterproductive at that point. The university's safeguarding threshold for when information could be shared was not considered met. There was no further contact with Brennan's father. It was agreed to refer Brennan's case to the statutory services if things escalated. Brennan had been given details of the Greater Manchester Mental Health crisis line and the support they provided.

2.28 The Norfolk Early Intervention Team had contact from Brennan's father on 26 November 2020 in which he expressed his worries that Brennan had a bank account which contained thousands of pounds and he might access this to purchase drugs or alcohol. Brennan's father confirmed that during contact with Brennan's mother in Thailand, she reported no concerns related to the situation, and Brennan was not reporting psychotic thoughts or thoughts of self-harm. His father was advised that if he feels any threat from Brennan to contact emergency services.

2.29 Towards the end of November Brennan was contacted about his absence from tutorials and workshops followed by an email from his tutor on 3 December 2020, Brennan responded to his tutor via email saying:

"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. Brennan did not meet his tutor on that date (he had already left Manchester), and he made no further contact with his tutor.

2.30 Despite strict Covid restrictions in place in Manchester at the time Brennan had journeyed to Norfolk and unplanned, turned up at Sofia's home firstly one brief occasion when his father gave him money for what he thought would be a return ticket for Manchester. Brennan's father called the Early Intervention Team and the clinician recorded he was not able to identify, 'any odd or concerning behaviours', apart from his concern that Brennan had possibly 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 an appointment

with his son which was offered for the following week. Brennan's father contests this record reporting to the chair that he wanted the Early Intervention Team to come as soon as possible, hopefully the same day, as he had expected Brennan to leave soon to go back to Manchester. Brennan's father did not know that Brennan had already decided to leave the university.

2.31 Brennan turned up a second time in the evening a few days later and asked to stay. Around midnight Brennan's father called the Police on 999 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 no damage had occurred.

2.32 Officers were dispatched to the property whilst the call handler continued speaking with Brennan's father; they arrived at 00:07hrs. Body worn cameras[11] were switched on as officers reached the front door; they were let in by Brennan's father who appeared distressed. The officers went to Brennan's bedroom which was in darkness; an officer switched on the light revealing him in bed 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. A third officer, a sergeant, arrived and it was agreed one officer would speak to Brennan's father downstairs. Two of the officers attending had been involved in the incident in May 2020 which resulted in Brennan being detained and Sectioned.

2.33 The officer 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 background information including about his son's behaviour in Thailand and his serious mental health problems. He explained that Brennan was very intelligent and knows what to say to a doctor to get himself released. Brennan's father relayed the events leading up to his phone call explaining that Brennan *"was staring at me; last time he did that he started getting violent with me."* The officer asked what he meant by getting violent with him and was told that he had kicked the door down. The officer asked whether Brennan had hit him, and he replied *"not this time, but he was threatening me, the way he was staring at me…"* Asked whether he believed Brennan was about to assault him his father replied *"well I was really frightened…* [although he did not fully finish the word]*; that was exactly what he did before he hit me last time. He was acting completely irrationally."*

2.34 Meanwhile In Brennan's bedroom officers asked further questions a majority of which received one word answers. Brennan remained in his bed. Asked where his phone was Brennan said, "*No idea*". Brennan was asked *"What is going to happen when we leave?"* and he replied *"Sleep".* Officers ended their interview with Brennan recommending he sleep and not speak to his father or interact with him. There was no audible reply from Brennan.

2.35 Downstairs an officer explained to Brennan's father 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. They continued to discuss Brennan and his father again

[11] 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.

explained *"I can't handle him in the house, I am sorry."* The officer explained 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,"* and he believed as soon as the Police left Brennan would threaten him. He wanted Brennan taken away. The officer explained no criminal offences had been identified for which Brennan could be arrested so they could not [take him away], and there was no accommodation for him to go to at that time[12]. Officers recommended that Brennan's father ask him to leave in the morning; he could go to the council. He was also advised to contact the Mental Health Crisis Team if he felt it necessary.

2.36 Brennan's father was told that Brennan was *"going to go to sleep, he is calm, he is just going to go to sleep"* and he was not going to speak to his father. The sergeant advised Brennan's father to go to his own room and shut the door, but he said he had no lock on the door. He was advised to place something behind the door. At the end of the discussion the officers waited a short while until he had gone to bed before leaving. The investigation was recorded at 01.05hrs as a non-crime domestic abuse investigation which highlighted that no criminal offences had been identified. No risk assessment was undertaken.

2.37 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 and to send him for a mental health assessment.

2.38 At 06:41hrs a call was received by the Fire & Rescue Service from a person delivering a newspaper to Sofia's home. 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 trial 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. Investigations identified the fire started in a cupboard under the stairs; a chair had been placed in front of the cupboard door.

2.39 At 08:07hrs a 999 call was received by the Police from Brennan's father. He had switch on his phone to find the fire alarms were going off. He explained he had left the house after the Police visit that night as he was scared of his son. He was scared his son had done something to the house. He was advised to stay where he was and someone would come and see him.

2.40 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[13]. Psychiatric reports for the court agreed a diagnosis of Hebephrenic Schizophrenia[14] a dissocial personality disorder and polysubstance misuse. The court accepted a plea of manslaughter due to diminished responsibility and

---

[12] Covid restrictions affected the availability of hotel accommodation.

[13] 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.

[14] 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 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)]

arson being reckless as to whether life would be endangered. Brennan was sentenced to a Section 37 Hospital Order and a Section 41 Restriction Order under the Mental Health Act in October 2022.

3. Key Issues Arising from the Review:

3.1 An over-riding issue from the review is the invisibility and lack of consideration for Sofia by the agencies involved. No practitioners consulted her in person about the safeguarding concern. No practitioners spoke to her about having Brennan returned to her home when he was discharged from his first Section. No one spoke to her directly to confirm whether she indeed consented to Brennan's return to her home when he 'ran away'. And no one spoke to her to establish whether she had heard what was taking place between Brennan and his father, and whether she felt safe when the Police attended on the fateful night. She was ignored by all.

3.2 Family concerns were not fully appreciated or taken note of. There was a lack of professional curiosity to inform assessments including risk assessments. An holistic approach particularly using the 'Think Family' practice model when assessing and planning Brennan's care pre and post-discharge would, and should, have involved Sofia as a close relative and the residing homeowner to where he was to be discharged.

3.3 There was no consideration or recognition of domestic abuse in assessments including considering risk. Although intimate partner domestic abuse is understood, familial domestic abuse was overlooked. Brennan's substance misuse from a young age and initial diagnosis of 'transient psychosis with mental health secondary to the use of cannabinoids' should have been factored into assessments and considered in the context of risk of family domestic abuse. An analysis of 66 adult family homicide DHRs[15] 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. In assessments Brennan denied any thoughts of harming others, and this appears to have been accepted. Sofia's frailty and health vulnerabilities were never considered nor why she was scared of Brennan.

3.4 Practitioners did not consider that family members who do not have experience of using public services find it difficult to navigate and understand services' structures, how they work, and the various job roles within them. Straightforward, jargon free, information needs to be provided at an early point of contact. There is a sense that information shared by Brennan's father and information given by services were perceived and understood differently by both parties. Again, this highlights the important issue of staff checking, recording, and feeding back information to ensure the full meaning of what is imparted is comprehended correctly.

3.5 The review identified a significant issue with privately purchased wi-fi enabled fire alarms. The devices installed in Sofia's home whilst up to date and modern, had only been linked to one mobile phone and it was switched off at the time of the fire. This raises important safety issues concerning the fact that these products can function without being backed-up with additional alternative devices installed in case a device is unavailable to receive alerts.

---

[15] 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

4. Conclusions:

4.1. From what we have learnt of Sofia during this Review she was an independent 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.

4.2. 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.

4.3. 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 seemed 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 an 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.

4.4. 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 being 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 his 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.

5. Lessons to be Learnt:

Hearing the Voice of Older Adults

5.1 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.

5.2 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.

5.3 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.

5.4 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

5.5 The Think Family approach recognises and promotes the importance of a whole-family approach[16] 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.
- 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).

[16] Think child, think parent, think family: Introduction - Think Family as a concept, and its implications for practice (scie.org.uk)

5.6 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.

5.7 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:

5.8 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[17]. 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.

5.9 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.

5.10 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?

5.11 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)[18] 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*

---

[17] 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)]

[18] [Domestic-abuse-older-adults.pdf (norfolksafeguardingadultsboard.info)]

specialist services. It is also essential to share information where you are concerned that a person is at risk of serious harm" (p2).

5.12 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 overroad the stated importance of working in partnership with other agencies to share information and 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:

5.13 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.

5.14 Norfolk's Safeguarding Adults Board[19] 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.

5.15 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.

5.16 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 the Overview Report for 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 members should always be factored into risk assessments in such cases and reviewed regularly.

5.17 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."[20] It is therefore important that all services and

---

[19] ibid

[20] 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

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:

5.18 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.

5.19 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.

5.20 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.

5.21 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 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 can be the outcome.[21] 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.[22]

5.22 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 Early Intervention Team were

---

[21] 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)

[22] "How Trauma Can Affect Communication" 28 January 2021. How Trauma Can Affect Communication — Sana Counselling

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.

5.23 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

5.24 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.

5.25 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:

5.26 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 a minimum of two devices linked to receive alerts when an alarm has been activated. This issue was also shared with the National Fire Chief's Council leads to raise the matter nationally. The Norfolk Fire & Rescue Service website[23] was update with this advice on 29 September 2023.

5.27 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.

5.28 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

[23] Smoke alarms - Norfolk County Council

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 at the time of writing. A recommendation regarding training remains to ensure continued governance of the process.

5.29 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.

5.30 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.

6. Recommendations from the Review:

6.1 The following recommendations arise from the lessons learnt during Panel deliberations and from agency IMRs. Family members have also contributed. Timescales will appear in the action plan.

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.

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 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 firstly 6 monthly after implementation and thereafter annually.

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 to:
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 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.

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 by September 2023.

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 applicate 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'[24].

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 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

[24] 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.

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 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.