Domestic Homicide Review

“Holly” who died in June 2022

LDHR28 Overview Report November 2023

Chair and Author: Fiona Bateman

Contents

Glossary

Acronym	Definition
A&E	Accident and Emergency hospital department
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CSEW	Crime Survey for England and Wales
CRHT	Mersey Care Trust's Crisis Resolution Home Treatment team
DHR	Domestic Homicide Review
EUPD	Emotionally Unstable Personality Disorder (also sometimes referred to as 'Borderline personality disorder)
IDVA	Independent Domestic Violence Advocate
KLOE	Key Line of Enquiry
LCC	Liverpool City Council
LDAS	Liverpool Domestic Violence Service
MARAC	Multi-Agency Risk Assessment Conference
MDVS	Merseyside Domestic Violence Service
MHLT	Mersey Care Trust's Mental Health Liaison Team
PCC	Police and Crime Commissioner
PDM	Police Decision Maker
RASA	Rape ad Sexual Assault (ISVA service commissioned in Liverpool)
RLUH ED	Royal Liverpool University Hospital Emergency Departments
TAU	Treat as Urgent – notification placed by police on vulnerable victims of crime addresses
VPRF1	Vulnerable Person Referral Form – notification sent by police to Careline

1 Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to 'Holly' a resident of Liverpool prior to the point of her death in June 2022. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before her death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 Liverpool CitySafe Partnership [hereafter referred to as the 'Partnership'] commissioned this Domestic Homicide Review ['DHR'] following Holly's death as she had previously reported significant deterioration in her mental health due to harassment/stalking from her ex-partner, [hereafter referred to as the perpetrator]. This review will be conducted in line with the statutory guidance under s9(3) of the Domestic Violence, Crime and Victims Act 2004 and the final review report and executive summary will be subject to oversight from the Home Office Quality Assurance Panel.

1.3 In April 2022 Holly reported to police she had received unwanted and abusive contact from the perpetrator (her ex-partner), including calls and texts on 18 occasions between March- mid April 2022. The Police recorded the incident as 'stalking'[1] and submitted a VPRF to Liverpool City Council's Careline later that month. Following this disclosure, Holly also sought support from her mental health team and received advice from LDAS and Liverpool's IDVA service. Shortly before her death she had posted a message on social media in early June 2022, citing the continued stalking as the principal factor in taking an overdose of her pain medication.

[1] Crime data reporting requirements set out for police to record any allegation of persistent unwanted contact that is capable of inducing fear for the victim as a crime of stalking even if, on closer examination of the allegations the level of contact or impact equates to the offence of harassment.

This triggered assertive intervention by staff from WHISC[2], persuading her to seek medical attention. Following WHISC and police intervention, Holly attended Royal Liverpool's Emergency Department but refused physical examination. She reported she had no protective factors in her life and did not feel able to keep herself safe. She was assessed by Mersey Care's Mental Health Liaison Team ['MLHT'] and discharged later that day into the care of Mersey Care's Crisis Resolution Home Team ['CRHT']. Despite phone calls and cold call visits to her home, she was not seen by that team, so three days later they raised a request for the police to carry out a welfare visit. Holly's body was found the following day.

1.4 Holly described herself as someone who had been '*the victim of many forms of abuse, some recently. I am an emotional person; this does not make me a bad person… I am loyal, honest (sometimes too honest), kind, caring, empathetic, patient...*'[3] Those who knew her well described someone who had suffered many years of trauma, but who demonstrated genuine warmth, kindness, and care for members of her support group. They spoke of an organised, determined woman, full of ideas for fundraising and happy to work quietly in the background but who was keen to get back into work and find a vocation. They remembered her as a bright, sometimes fierce champion for those who had suffered injustice and described her death as a huge loss. The rose on the front cover of this report was planted in memory of her by members of a victim survivor group upon whom she had had such a positive influence.

1.5 The reviewers wish to express our sincere condolences to Holly's family, friends and to all those who knew Holly. The reviewers are very grateful to her brother and practitioners who worked with Holly for their insight into the challenges in trying to support her to stay safe and sharing so candidly their thoughts on what could make a meaningful difference to reduce future deaths of victims of stalking behaviours.

2 Governance: Purpose of a Domestic Homicide Review

2.1 The review will consider agencies contact and involvement with Holly between April 2021 (when it is understood the relationship resumed) until Holly's death In June 2022. In addition to agency involvement during the review period, the report includes relevant details from her past to understand the trail of abuse she experienced before her death, whether there were any barriers to accessing support and to understand the predictive factors present in this case. In recognition of Holly's additional care and support needs, this report will also explore how agencies can work more effectively to recognise and respond when an adult with care and support needs is unable to cope with additional distress caused by domestic abuse, including harassment and stalking, such that it increases the risk of self-harming or suicidal ideation. The report has also reviewed contact and involvement by agencies with the perpetrator between June- December 2022 in respect of the investigation and decision making into the stalking allegations.

2.2 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person dies as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

2.3 This review began in May 2023 and was completed in November 2023. Reviews should be completed, where possible, within six months of the commencement of the review. The review was undertaken in compliance with expectations set out within Statutory Guidance.[4]

Confidentiality

2.4 The findings of each review are confidential until publication. Information is available only to participating officers/professionals and their line managers. The pseudonyms of 'Holly' has been agreed with Holly's family and used in the report to protect the identity of the individuals involved. We have referred to her ex-partner as the perpetrator at the request of her family.

2.5 Holly was a white British woman who was aged 42 at the time of her death in June 2022.

2.6 The perpetrator was a white British man who was aged 42 at the time of Holly's death.

Terms of Reference and Methodology

2.7 The Domestic Abuse Act 2021 ['the 2021 Act'] clarified the different relationships within which domestic abuse can occur.

It confirmed any abusive behaviour that occurs between two people (16 or over) who are 'personally connected' to each other should now be responded to as domestic abuse. This includes people who are, or have been, in an intimate relationship. The 2021 Act also amended s76 Serious Crime Act 2015 to remove the cohabitation requirement so that, from 05.05.23,[5] former partners

[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Home Office, 2016 available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[5] The change in the law was not intended by Parliament to be retrospective, so would not have applied during the period under review. It is included here because the purpose of this review is to support future practice so will be relevant to policy makers and practitioners going forward.

experiencing post-separation controlling and coercive abuse can be safeguarded. The 2021 Act also introduced new measures designed to '*drive consistency and better performance in the responses to domestic abuse across all local areas, agencies, and sectors*.[6]

2.8 Four key offences concerning stalking and harassment are contained in sections 2, 2A, 4 and 4A of the Protection from Harassment Act 1997 [PHA 1997] and section 42A (1) Criminal Justice and Police Act 2001. In 2012, the Protection from Harassment Act 1997 was amended to insert (at s.2A) the specific offence of stalking. Under s2A, a person is guilty of an offence if- the person pursues a course of conduct that amounts to stalking. A '*person's course of conduct amounts to stalking of another person if:*

> *(a) it amounts to harassment of that person,*
> *(b) the acts or omissions involved are ones associated with stalking, and*
> *(c) the person whose course of conduct it is knows or ought to know that the course of conduct amounts to harassment of the other person.'*

Section 3 goes on to provide examples of acts or omissions which, in particular circumstances, are ones associated with stalking, namely:

> *(a)following a person,*
> *(b)contacting, or attempting to contact, a person by any means,*
> *(c)publishing any statement or other material—*
> *(i)relating or purporting to relate to a person, or*
> *(ii)purporting to originate from a person,*
> *(d)monitoring the use by a person of the internet, email or any other form of electronic communication,*
> *(e)loitering in any place (whether public or private),*
> *(f)interfering with any property in the possession of a person,*
> *(g)watching or spying on a person.*

[6] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-bill-2020-overarching-factsheet

Section 4-5 explains, '*A person guilty of an offence under this section is liable on summary conviction to imprisonment for a term not exceeding 51 weeks, or a fine not exceeding level 5 on the standard scale, or both. In relation to an offence committed before the commencement of section 281(5) of the Criminal Justice Act 2003, the reference in subsection (4) to 51 weeks is to be read as a reference to six months*.'[7]

2.9 Harassment is defined as alarming a person or causing them distress (section 7(2) PHA 1997). The 'course of conduct' must comprise two or more occasions (section 7(3) PHA 1997), but do not need to be of the same nature. However, the court must be satisfied that the incidents are '*so connected in type and in context as to justify the conclusion that they can amount to a course of conduct*' Pratt v DPP [2001] EWHC Admin 483.

2.10 In addition to those offences, s76 Serious Crime Act 2015 introduced offences linked to controlling and coercive behaviours requires '*repeated or continued behaviour that is controlling or coercive*'.

CPS accompanying guidance warns prosecutors that 'the cumulative impact of coercive and controlling behaviours and the pattern of behaviour within the context of the relationship is crucial.'[8] This guidance goes on to list relevant behaviours and clarify that, to demonstrate the behaviour has a serious effect on the victim, a prosecutor only needs to prove the victim feared violence on at least two occasions or serious alarm or distress had a substantial adverse effect on the victim's day to day activities.[9] Allegations can be tried summarily or on indictment and have a maximum penalty of five years' imprisonment.

[7] Protection from Harassment Act 1997 (as amended) available at: https://www.legislation.gov.uk/ukpga/1997/40/section/2A

[8] Taken from CPS guidance (available at: https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship, accessed 23.08.23)

[9] S.76(4)(a) and (b) of the Serious Crime Act 2015.

2.11 The terms of reference for this review were agreed by the Domestic Homicide Review ['DHR'] panel on 12.06.23. This has taken into consideration the guidance issued by the Home Office[10], it also incorporates tools from Learning Together and SAR In Rapid Time methodology. The learning produced concerns 'systems findings' to identify social and organisational factors that make it harder or easier to proactively safeguard in response to domestic abuse, within and between agencies. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Holly from harm.

2.12 The partnership prioritised the following key lines of enquiry [KLOE] for illumination through the DHR:

i. Following disclosure in April 2022 by Holly of the frequent, abusive contact from her ex-partner to the Police, was appropriate action taken by police to gather evidence in line with expected standards.

ii. Is the distinction between offences under the Protection for Harassment Act 1997 understood by relevant partners in Liverpool?

iii. Were stalking risk assessments completed by agencies following Holly's disclosure of the contacts and the impact this was having on her mental wellbeing?

iv. What was known about Holly's presentations and previous intentional overdoses, was sufficient information shared across agencies involved in her care to evaluate the risk properly, given her heightened anxiety caused as a result of the harassment?

v. How well does risk evaluation between Careline, the police's internal MASH and MARAC processes work where the adult at risk is known to have enduring mental health conditions?

[10] Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office, 2016)

vi. Were CPS involved in a timely manner, according to expected standards and notified of the impact of the abuse on Holly? Is there evidence that the CPS took the circumstances of her death into account when determining this as a summary offence?

2.13 In addition to policy and research materials referenced throughout the report, this review was supported by the provision of case records and management review reports provided by agencies listed in the table below.

Agency	Documentation provided
Citysafe Partnership	DHR standing group minutes, Collated background information and combined chronology
Liverpool City Council	Adult Social Care IMR
Mersey Care NHS Foundation Trust	Chronology and IMR, Core 24 assessment (dated 02.06.22), Suicide prevention policy and Personality Disorder Policy applicable during the review period
Merseyside Police	Chronology and IMR, the initial log of crime and VPRF (completed 20.04.22), storm log, charging decisions (1-4). Log of attendance on 05.06.22
ICB	Summary of Agency information and involvement, including GP chronology for Holly and, separately, her ex-partner
LDAS	Chronology and IMR
IDVA	Chronology and IMR
CPS	Stalking and Harassment Protocol (between National Police Chiefs' Council and CPS)
Coroner	Record of inquest, post mortem report and Mersey Care's witness statement

Involvement of Family and wider community

2.14 The reviewer and Partnership wrote in June 2023 to Holly's brother, providing a copy of the Home Office DHR leaflet and setting out the purpose and scope of the review. They were offered advocacy support. Her brother and nephew met with the reviewer in July 2023 so that the terms of reference could be shared. They provided their perspective of who Holly was and the challenges she faced. Since her death, her brother has taken an active role in sorting through her belongings, finding additional evidence she had recorded of the level of abuse she was experiencing. Her brother explained the steps he had taken to bring this to the attention of police. He also became aware that, prior to her death, she had incurred significant debts and therefore would likely have been experiencing additional pressure. He continues to advocate on her behalf to understand how decisions regarding her care and risk management were made.

2.15 Her brother met again with the reviewer in October 2023 to explore the findings and recommendations and expressed his gratitude to all those involved in this review and the serious incident investigation. It meant a lot to him to understand what happened to his sister and that lessons would be learned from her experience. He has asked to be kept informed of the impact of actions taken as a result of this review. The reviewers are very grateful to her family for supporting this review.

Contributors to the review

2.16 On 20.06.23 the reviewer met with staff from WHISC (who knew Holly and worked alongside her to support her recovery) to better understand who Holly was.

They spoke of how guarded she was of her past childhood experiences and about how attempts to discuss with her family or personal support networks triggered obvious distress. The discussion considered how Holly's previous adverse experiences and diagnosed mental disorder increased the barriers for her to access support in the context of what WHISC had done for her (and what she had done subsequently for other people) to enable access to their services.

WHISC also spoke of how the insidious nature of the abuse she was suffering coupled with her disabilities was overwhelming. This is explored in more detail below. We also explored what motivated her in respect of her recovery from poor physical and mental health and, most importantly, what she had reported to them following her intentional overdose on the 02.06.23. WHISC also participated in the learning events and met with the reviewer to provide feedback on the overview report. We are so grateful to them for their insight and for contributing to this review despite their obvious distress at the death of a colleague. Their input has enabled her voice to inform this report.

2.17 Multi-agency learning events took place in July 2023 with front-line practitioners who worked with Holly and the leaders who oversaw the services involved in supporting them. The reviewer also met with senior CPS personnel who had reviewed the file.

The Review Panel Members

2.18 The Reviewers were supported to complete this review by the review panel, the membership of which is listed below. The panel met initially on the 12.06.23 to agree terms of reference, the methodology and panel membership. Panel members confirmed they were independent as had not previously been involved in the case or had responsibility for line managing staff supporting Holly.

It was agreed that to avoid any possible conflict of interest, because of their direct interventions to support Holly and her previous volunteering work within the service, WHISC staff would contribute their views and experiences through meetings with the reviewer and involvement in the learning events rather than panel membership. The panel contained representation from domestic abuse services who did not know Holly personally.

Name	Organisation/Title
Fiona Bateman	Safeguarding Circle: Independent Reviewer and chair of panel
Michelle Hulse	Team Leader Victims and Vulnerable People, Safer and Stronger Communities, Liverpool City Council
Lisa Estlin Debbie Phillips	Risk Assessment Coordinator for LCC Safer & Stronger communities, Domestic Abuse officer for LCC Safer & Stronger communities
Ayla Nasuh	CEO, Merseyside Domestic Violence Service
Carla Whittaker Sarah Shaw	Named Nurse for Safeguarding Adults, Mersey Care NHS Trust Assistant Director of Safeguarding, Mersey Care NHS Trust
Carmel Hale	Designated Safeguarding Nurse, ICB
Jayne Cooke	Advanced Public Health Practitioner, LCC Public Health
Clare Kimber	Operational Manager, Independent Domestic Violence Advocate
Sandy Williams	Head of Safeguarding and Assurance, LCC Adults Social Care
Emma McLean	Designated Safeguarding Lead, LCC children & families social care department
Holly Chance	Detective Inspector, Merseyside Police

2.19 On the 13.07.23 panel members met again to the case information which had been collated into an early analysis report to facilitate a system wide view of activity with Holly. This report identified themes emerging and correlated this to learning from national best practice or learning reviews with similar issues. Having reviewed the report, the panel wished to draw attention to how isolated Holly was and how alone and unheard she must have felt in her final days.

2.20 At the meeting on the 13.07.23 Panel members unanimously agreed, having reviewed case records and after careful consideration, that it would not be appropriate to request the perpetrator directly contribute to this review. This decision was taken as it was clear the perpetrator had very little contact with services prior to Holly's death. Also, because he has shown no remorse or insight for the adverse impact his behaviours had on Holly's mental health. It is also understood that, separately, his health has deteriorated since and could be adversely impacted further by involvement in this review.

2.21 As very little is understood of his motivation or his view of the impact that his persistent calls would have had on Holly, the partnerships are grateful for the active involvement from Merseyside Domestic Violence Service [‘MDVS’] who were able to draw on their expertise in delivering preventative support to perpetrators of stalking and harassment to inform this review.

They advised that addressing the behaviour of a stalker is a complex issue that requires a multi-faceted approach, ensuring both the safety of the victim and taking into consideration the motivations behind the perpetrator's behaviour, i.e., obsession, revenge, control, to invoke fear or another motive. Identifying the correct intervention hinges crucially on unravelling these motivations. For instance, while some perpetrators might benefit from behavioural change programs, such as those offered by MDVS, others might require in-depth mental health assessments and psychiatric treatments. In Holly’s case, as the perpetrator was the ex-intimate partner of Holly and could therefore be categorised as fitting the profile of a ‘rejected stalker’ in the Stalking Risk Profile, (SRP); notably, the primary motivators for such stalkers are either reconciliation or revenge (Mullen et al, 1999). Recognising this allows for more focused and effective approaches in addressing their behaviour. They explain, in such cases multi-agency collaboration is critical as the synergy between police, mental health services and agencies like MDVS can provide a broader understanding of the perpetrator, their underlying motivations, cognitive distortions, mental health, criminal history and other life challenges such as housing, employment or substance misuse issues. This collaboration is critical to offer the appropriate intervention that could allow the perpetrator to understand the gravity of their actions, both on their lives and those of the victim.

2.22 Research[11] indicates that some stalkers might be deterred by legal actions, while others might require psychological interventions. In some cases, even after undergoing a behavioural change intervention or therapy, a stalker's behaviour might persist, necessitating stricter measures. However, what is clear is that a comprehensive approach that seeks to understand and address the root causes of the stalking behaviour, while also ensuring the safety of the victim, is critical. By focusing on both prevention and intervention, it's possible to mitigate the impact of such behaviours and reduce their occurrence in the future.

2.23 The panel met on the 15.09.23 to review a draft report. At this meeting partners agreed to consider how their agencies would respond to prevent future harm by providing details of the actions they would take in response to the recommendations.

2.24 The Panel also met on the 17.10.23 and 07.11.23 to ratify the final report and agree the action plan. This is included within Appendix B.

Author of the Overview Report

2.25 In May 2023, Citysafe commissioned Safeguarding Circle LLP to conduct this Domestic Homicide Review.

Fiona Bateman (the author and chair) is a qualified solicitor and has worked for 20 years in safeguarding for children and adults, including providing advice to local authorities on health and social care responsibilities, strategic priorities, and good governance. Since 2014 she has also worked as an Independent Safeguarding Board Chair in London and the South-East. In 2020 she co-founded Safeguarding Circle, an independent safeguarding consultancy supporting systems improvements, complex case resolution between agencies and championing legal literacy through case workshops and training. Fiona has

[11] See Jerath, K., Tompson, L., & Belur, J. (2023). Treating and managing stalking offenders: findings from a multi-agency clinical intervention. Psychology, Crime and Law, 29(10), 1161-1184. https://doi.org/10.1080/1068316X.2022.2057981 and Brady, P. Q. (2024). How to Stop a Stalker: Perceptions and Predictors of Deterring Unwanted Pursuits. Crime & Delinquency, 70(6-7), 1836-1863. https://doi.org/10.1177/00111287221131010

extensive experience as an author of safeguarding adult reviews, child practice reviews, thematic reviews and domestic homicide reviews, exploring systemic response to issues such as transition to adult services, exploitation, co-morbid health, mental health and/or neurodiversity, self-neglect, homelessness and domestic abuse. Fiona is trained in SCIE's safeguarding adult review methodology and has completed the Home Office online training on domestic homicide reviews, including the modules on chairing reviews and producing overview reports. Fiona and Safeguarding Circle are not directly associated with any of the agencies involved in this review and had no involvement in the case.

Parallel reviews

2.26 At the time of completion, there was an outstanding investigation by the IOPC in respect of the police response to the request for a welfare check in June 2022. This has subsequently concluded there was no evidence of criminal behaviour by serving officers or anything that would justify brining disciplinary proceedings. In addition, Mersey Care NHS trust were completing a Serious Incident investigation.

2.27 Liverpool City Council's ['LCC'] Public Health department have, in accordance with their statutory responsibilities, completed reviews into deaths by suicides within their local area.

Their research has highlighted 40% of people who go on to complete suicide have made previous suicide attempts, so advise that this should be considered as an indicator of high risk. It is likely to require immediate response from those with public law obligations to protect life,[12] particularly if there are other additional risk factors. Common risk factors include a diagnosis of personality disorder,[13] co-morbidities with affective disorders (e.g., depression, eating disorders) or other long-term conditions (including chronic pain), recent

[12] In line with positive obligations under the Human Rights Act 1998 (article 2).

[13] Mersey Care's Suicide Prevention policy reports for people diagnoses with EUPD (otherwise known as Borderline personality disorder) 'It is well known that patients with BPD frequently present with repeated suicide attempts. Studies show that around 60-70% attempt suicide at some point in their life and 10% die by suicide (Paris 2001). It is reported that attempts are highest in the third decade, but completion is usually in the fourth decade (Vijay 2007).'

relationship breakdown or bereavement, poverty, experiencing coercive and controlling forms of abuse and social isolation/ loneliness.[14] In addition, all types of domestic abuse are considered a significant risk factor for suicide and may be underrepresented in existing intelligence. Many of these factors featured in Holly's lived experience.

Equality and Diversity

2.28 This review has also examined, by reference to relevant protected characteristics under the Equality Act 2010, to ensure services to consider what, if any, reasonable adjustments are needed to enable victims to be identified and examine any barriers to accessing services for appropriate support.

2.29 **Sex**: National Stalking Helpline data reported in 2012 the majority of victims are female (80.4%) while the majority of perpetrators are male (70.5%). International research supports these ratios, especially in cases where there is higher risk of physical harm.

It is found for example, that in the rejected stalker category, that where there has been a previous relationship between victim and stalker that most victims will be female, and also in the (relatively rare) predatory category.[15] More recent data from the Crime Survey for England and Wales[16] [CSEW] reports that during this review period, 146,000 women reported stalking in that last year by a partner or ex-partner and a further 81,000 men reported experiencing stalking offences. A further 467,000 women and 260,000 men reported cyber stalking behaviour. Women (0.6%) are therefore twice as likely to experience stalking than men (0.3%). In Liverpool there are programmes to support male perpetrators of stalking to recognise through Mersey Care NHS Trust, MDVS

[14] Public health's research identified that to address social isolation, those at high risk of suicide require meaningful connection. They explained in practical terms this requires agencies to report on actions they have taken in response to risk, to overcome any sense of hopelessness or abandonment.
[15] National Crime Data report 2012 and National Stalking Helpline data report available at: https://www.gov.uk/government/statistics/national-stalking-helpline-stalking-statistics
[16] Published by the Office of National Statistics and available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2023#domestic-homicide and, in respect of stalking findings: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/stalkingfindingsfromthecrimesurveyforenglandandwales

also offer support to all victims of stalking. This is detailed further below in response to relevant key lines of enquiry.

2.30 **Age:** Both Holly and the perpetrator were 42. The CSEW also reported that the highest prevalence of stalking reported by women by a partner or ex-partner (excluding cyber stalking) is within the 35-44 age range. Whilst Ciysafe's Equality Impact assessment concluded there were no barriers to this age range accessing services, they are unlikely to be in receipt of universal services (e.g. schools) that are typically able to recognise and offer early intervention to children.

2.31 Ethnicity: Both Holly and the perpetrator were White British. Nationally 4.4% of White British women experienced stalking, 0.6% by an ex-partner. Services strive to remove real or perceived barriers to accessing support due to a person's ethnicity. However, data in respect of all forms of domestic abuse identified from October 2022 to September 2023, 90% of recorded domestic abuse crimes were against White British victims (8280), although according to the 2021 national census, 77% of Liverpool's population was White British. This may indicate either that White British people may be more likely to experience domestic abuse, than other ethnicities or that ethnic minority groups may be under reporting domestic abuse.

2.32 **Disability:** Holly lived with both physical and mental disability. Local MARAC data from 2023-24 report 104/1893 cases involved victims with disabilities. Safelives has highlighted concerns that nationally there is underuse of the MARAC process to support disabled victims of abuse.[17]

It is notable therefore that during 2023-24 there were no referral from the Multi-agency safeguarding Hub and only 23/1893 cases were referred by LCC's Adult Social care. According to CSEW data, people with a longstanding illness or disability are disproportionately likely to be victims of stalking. 7.4% of women with a disability experiencing stalking, against 3.7% who reported they weren't disabled. However, it is also pertinent to note 6.2% of women and

[17] https://safelives.org.uk/sites/default/files/resources/Disabled_Survivors_Too_Report.pdf

2.3% of men who were economical inactive due to ill-health reported experiencing stalking. There is also an increased risk of suicides for women with disabilities who experienced stalking. The intersectionality of risk factors for suicide is discussed in more detail below as they are pertinent to the fourth key line of enquiry.[18]

2.33 Sexual Orientation: CSEW data reports most victims of stalking were heterosexual (4.3%, n,16,043), however a high proportion of victims were from the Gay/Lesbian (7.6%, n288) or bisexual (17.2%, n333) communities. Presently there are no specialist services for victims or for perpetrators within same sex relationships, though the panel remains an area of focus for the Partnership.

Dissemination

2.34 The Domestic Abuse Partnership Board reviewed the key findings and provisional recommendations on the 23.11.23 and the Partnership received the report on the 07.12.23. The report was then submitted to the Home Office Quality Assurance panel.

2.35 The report will be published and disseminated to partners of Liverpool's Community Safety Partnership, Safeguarding Adults Board and Safeguarding Children Partnership. The final report will be shared with the Police and Crime Commissioner for Liverpool and the Domestic Abuse Commissioner for England and Wales to inform their work.

[18] Research by the NPCC identified that during this review period, suicide had overtaken intimate partner violence for the first time. Available at: https://news.npcc.police.uk/releases/report-reveals-scale-of-domestic-homicide-and-suicides-by-victims-of-domestic-abuse#:~:text=Key%20indicators%20of%20risk%20present,separation%2Fending%20of%20the%20relationship.

3 Background information

3.1 Holly died in her home in Liverpool in June 2022, a postmortem report stated this was due to morphine toxicity. In December 2022 the Coroner provided a short verdict, concluding that Holly died of suicide.

3.2 Holly's brother explained that Holly and the perpetrator had known each other for some time. They had been previously in a relationship in their early 20s but that this had ended acrimoniously and that they had subsequently been separated for a number of years. The relationship resumed in April 2021. It does not appear from the case records that they lived together. Holly reported the relationship lasted 12 months and ended in April 2022 due to '*his emotional and verbal abuse*'.[19]

3.3 As noted below, the perpetrator was interviewed by police in respect of the stalking allegations, no charges were bought as the CPS advised that the time limits for charging the perpetrator had expired.

3.4 Following an Inquest in December 2022 the Partnership's DHR Standing Group reviewed the case in January 2023, initially concluding it did not meet the criteria for a DHR. However, following feedback from the Home Office Quality Assurance Panel who believed there may be significant learning with respect to responses to stalking, the Standing Group agreed on the 27.03.23 to recommend commissioning a review.

[19] Taken from the Police Chronology submitted for this review.

4 Chronology

4.1 We know from police records and her own account that Holly had suffered serious abuse in her childhood.[20] She had a diagnosis of Emotionally Unstable Personality Disorder ['EUPD'] with Anxiety and Depression and had a history of self-harming behaviour, including intentional overdoses. Clinical records document '*chronic suicidal thoughts'*. She disclosed she suffered from non-purging bulimia. But (again in her own words) asked not to be underestimated and for people not to '*judge everyone with the same diagnosis with the same brush, as we are all different. Walk a mile in a person's shoes before ever thinking of judging them*.'

4.2 In addition to the serious childhood abuse Holly experienced, it is understood she had two children, who are now both young adults. Both these children had been removed from Holly's care by the local authority and placed with adoptive families, separately. It is believed that her son lives with his adoptive family abroad, but that she resumed contact with both in their adulthood and that re-establishing these relationships was important to her.

Whilst the circumstances surrounding their adoption are not part of the review, it is highly likely this would have been a traumatic experience for Holly. The likely impact of this was discussed during panel meetings and with practitioners who knew her but very little was known about how this had impacted on her as she was not comfortable to talk about her past. We know, however, from research[21] that, sadly, the experience of losing care of children also increases the risk of long-term poor mental health for the mother and is a high-risk indicator for women completing suicide.

[20] Holly disclosed sexual abuse as a child and police records also report abuse by her father, it is understood that she had secured orders to prevent her father making contact with her. But her brother reported she remained in contact with other family members and was close to her niece.

[21] Elizabeth Wall-Wieler, Leslie L Roos, Nathan C Nickel, Dan Chateau, Marni Brownell, Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis, *American Journal of Epidemiology*, Volume 187, Issue 6, June 2018, Pages 1182–1188, https://doi.org/10.1093/aje/kwy062 but see also https://hubble-live-assets.s3.amazonaws.com/birth-companions/file_asset/file/497/Still_a_Mam_Report_-_Final_Version__PDF_.pdf

4.3 Police records indicate that Holly was the victim of sexual assaults in 1999 and 2004. Holly also made reports of burglary and criminal damage on fifteen occasions between 2000 and 2021. The perpetrator was not involved in any of those incidents. She has no record of domestic incidents with previous partners, though it is understood that she had been in an on-off relationship with the perpetrator for many years.

4.4 Holly was known to Crisis Skylight between May 2015 - May 2018 and engaged in a range of programmes to address homelessness, poor mental health associated with trauma and employment support. Through this service she was referred for a statutory assessment of her mental health to the Community Mental Health Team [‘CMHT’] in June 2016 and has been known to CMHT from that time. She was also referred and received counselling from RASA between Jun 2016 - Jan 17.

4.5 In March 2021 Holly reported she had found the national lockdown (in response to the Covid Pandemic) very difficult as she was very isolated. It was recorded within Mersey Care case records that she had a blood clot after first covid vaccine so was not suitable for second dose. She had been identified as clinically vulnerable and so, if she remained unvaccinated, this would likely have increased her social isolation because the virus was still widespread in the community. This would have prevented her from accessing social support groups which, prior to the pandemic, had formed a significant part of her care plan.

She discussed this with CMHT duty staff who offered reassurance, but there is no evidence that her concerns or the practical restrictions on her of attending social support groups triggered a review of her care plan.

4.6 Between April 21- April 22 Holly had 39 contacts with her GP. She had several cooccurring conditions in addition to her mental health diagnosis, including problems with her breathing (Asthma), pain requiring ENT referrals and knee pain and mobility issues. During this period Holly was also under the care of a pain consultant for back pain and chronic fatigue syndrome. This was largely managed between a private provider and her GP, through prescribed medication (including 1 x 300ml bottle of morphine a month).[22] Her case notes reported that over the last few years she had not been ordering more than prescribed or appearing to overuse. She was also under the care of a consultant at a weight loss clinic, in respect of her weight issues resulting from non-purging bulimia.

4.7 Her mental health support was primary delivered through the CMHT. In line with policy applicable at the time, her consultant psychiatrist completed a review in May 2021 during which Holly complained of issues with her prescription of melatonin. She reported that she was compliant with other medication. She also disclosed emotional dysregulation resulting in anger issues with new partner and was keen to work at psychological level. She denied any suicidal or self-harming intentions and was hopeful for her future. Within their IMR Mersey Care recognised this was a missed opportunity to explore risks associated with domestic abuse. It was understood that social isolation was a key risk in a deterioration of her mental health. Her clinical notes stated she '*reported to be aware of crisis numbers. Referral to psychology services to be made by medic. Further review planned in four months' time*.'

[22] Issued 300mls Oramorph – 17th May, 19th April, 21st March, 7th February 2022. NB: NWAS reported '2 empty bottles of oramorph on scene' on 06.06.22. In addition, she had been prescribed Pregabalin (300mg), Nefopam (30mg), Marcogel sachets, Salamol inhaler, Qvar, Doxyclclin, Fenbid, Folic Acid. Side effects for Oromorph includes respiratory depression, confusion, and uncommon reactions include drug dependency. Side effectis for other medications included abdominal pain or gastrointestinal discomfort, headaches. Very rare reactions to Qvar include sleep disorders.

4.8 In August 2021 the duty mental health practitioner returned a call from Holly where she reported she was struggling with increased anxiety but had been unable to identify a possible trigger. She spoke about being worried to leave the house and reported thoughts of stabbing herself in the leg. Although she denied any active plans of suicide, she was honest about self-harming previously. She explained she had run out of melatonin and was requesting a further prescription from the consultant psychiatrist. The duty mental health practitioner advised her that she would email the consultant regarding a prescription. Holly asked if her appointment could be brought forward to discuss psychology options due to increased anxiety and her medication, in response she was provided the team's duty number and numbers for urgent care services. Holly confirmed she would contact the appropriate services if she felt that she required crisis support. Whilst the duty worker emailed Holly's consultant psychiatrist, it was not possible to bring forward her review in accordance with Holly's wishes or consideration given to the impact her physical ill-health was having on her mental health. Her risk assessment was not updated to reflect thoughts of self-harm. Unfortunately, her scheduled appointment in September had to be cancelled by her psychiatrist due to '*urgent unavoidable issues'* and an explanation was given as to why the appointment was cancelled.[23] Holly was called and a message left on her voicemail to offer replacement appointment for mid-October. Holly emailed back to advise *"she has been feeling unwell for a while and has been holding on by the skin of her teeth until tomorrow to speak with the doctor'.*

Her case record noted *'patient said she cannot wait until her October appointment to speak with someone, can she get a call please?'*[24] The duty mental health practitioner then spoke over the telephone with Holly, who confirmed her anxiety was 'worse', and when asked to identify what she was struggling with most she stated that she '*feels unable to go out, scared to get in the shower due to beliefs someone will assault her*.' Whilst her case notes report the duty mental health practitioner spent time validating her distress and

[23] Taken from Mersey Care's case records collated into a chronology submitted for this review.
[24] Taken from Mersey Care's case records collated into a chronology submitted for this review.

providing advice around identifying and working with intrusive thoughts. It does not appear, again, that inquisitive enquiry was used to ascertain if she was experiencing a threat of assault. Holly explained she was using the advice given by her psychologist.[25] After reviewing notes, the practitioners concluded her '*presentation over the phone seemed fitting with long standing presentation and she did not appear in crisis'*.[26] The duty practitioner offered an earlier appointment with a junior doctor, but Holly refused this and was advised it was therefore unlikely she would get an earlier appointment. She was asked what she was hoping from her outpatient appointment and Holly explained she wanted her medication reviewed. Her case notes record Holly '*understood that she was already prescribed a high level of medications*' and she was advised to consider engaging with the Umbrella Centre[27] and that the duty worker would ask Holly's CMHT support worker to contact her to discuss whether there were any activities she could become involved in such as the walking group and adult learning classes. Holly responded that she had been trying to go out alone however had been finding it difficult. She explained her boyfriend[28] had been struggling to understand her agoraphobia and that she didn't feel comfortable attending some groups due to males being present. The duty practitioner subsequently sent an email to Holly's CMHT support worker and the team secretaries to discuss her needs at the next CMHT's Multi-Disciplinary Team meeting ['MDT']. Holly attended a cookery group in late August 2021.

4.9 At the end of September 2021 Holly was discussed in the CMHT's MDT, her request for an earlier review appointment could not be facilitated.

The CMHT support worker concluded there was no requirement to change her current treatment plan as she was attending the cookery group and had been managing well. This concords with Mersey Care's Personality Disorder policy which encourages positive risk taking to increase the person's agency and coping abilities, but as noted in their IMR, this was another missed opportunity

[25] It is understood that Holly received psychological input until February 2021

[26] Taken from Mersey Care's case records collated into a chronology submitted for this review.

[27] The Umbrella Centre is a Wellbeing Centre which provides recovery-focused mental health support to people living in Liverpool and is provided by PSS.

[28] This was a new relationship, not the perpetrator of the harassment

to review and update the risk assessment to better support Holly cope with the additional pressure she was experiencing.

4.10 In October 2021 her CMHT support worker visited Holly at her home, whereby the worker identified a high level of clutter suggestive of hoarding behaviours. In conversation with the reviewer, her family explained that the level of clutter would have severely restricted her ability to use her home safely.[29] Holly reported she did not want to get rid of anything, but her support worker made a plan of action to include what stays and what goes. Holly agreed that she would try and do small tasks each day as otherwise she will become overwhelmed. Her housing provider has since confirmed to this review they have a policy setting to support tenants address concerns often linked with hoarding for anyone within their general needs or sheltered accommodation. This is delivered by a specialist team who offer a trauma-informed service designed to assist their tenants who might be 'overwhelmed by the possessions they have in their property'. This service offers '*intensive, long term at home support to organize, sort and discard possessions. We aim to change a customer's perspective around possessions, rather than just clearing properties*.' It also facilitates a peer support group 'hoarders helping hoarders'.

4.11 Later that month her case was reviewed by way of a telephone consultation. Her case notes record a plan to '*follow up previous psychology referral and review in a further 3 months*.'

During an MDT the following day, the psychologist advised they had not received a referral for Holly and, given she had only recently completed psychological intervention, it was their view that she should not be referred for

[29] They described spending three days sorting her flat, but that still it required the landlord to bring in a specialist team to continue to clear. They sorted over 20 boxes of documentation. They also found significant 'stockpiles' of her medication and over 100 boxes of embroidery thread and wool for knitting. They explained that she was not able to access her kitchen, bedroom or bathroom because of the 'clutter'. Despite the level of hoarding, the property was very clean (she had stockpiled cleaning materials also), but recognised that the state of the property represented a risk to her safety and, more widely, public safety due to fire risks. He rated the property at level 7-8 of clutter (as according to the clutter rating index, available at https://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf).

further psychological intervention '*for some time'*.[30] It was agreed that the consultant psychiatrist would feedback this to Holly and apologise for any miscommunication, but there was no evidence that the MDT spoke with her GP or Holly. Previously she had been offered alternative opportunities to support Holly, she had declined these. It does not appear that this information had been passed to her when, 2 days later, her CMHT support worker met with Holly at home and Holly explained she had been unable to complete tasks set to clear each room. Holly reported that she was feeling overwhelmed by the task. Her support worker advised '*she needs to refer to the plan which was completed …which focused on cleaning/tidying a room at a time rather than going from room to room. [Holly] bagged all the junk out of the living area and broke up all the large cardboard boxes that had been accumulated over time. [She] had managed to declutter part of the lounge. No new concerns identified from this contact.*'[31] Whilst, following her death, Holly's brother reported there were medication stockpiled in her flat it does not appear that the support worker had seen these or specifically asked about this as this had not previously been a feature of Holly's presentation. There were opportunities to use local multi-agency safeguarding policy, or implement the Hoarding Protocol, DATIX system or send notification to the safeguarding team regarding concerns of high level of hoarding.[32]

It does not appear hoarding behaviours and her reported anxiety at seeking to declutter was discussed with the consultant psychiatrist. In early November, Holly attended the cookery group, but there were no further contacts with CMHT until a scheduled review at the beginning of March 2022 where she reported her anxiety had increased following a decision by her GP to discontinue her Pregabalin medication.[33] Her case notes documented that she

[30] Prior to the timeframe under review for this DHR Holly had accessed psychological therapy including a course of Eye movement desensitization and reprocessing [EMDR] therapy. A break was recommended before any further therapy was commenced, because although Holly did engage in therapy, she found this difficult at times due to flashbacks relating to her childhood abuse (physical and sexual perpetrated).

[31] Taken from Mersey Care's case records collated into a chronology submitted for this review.

[32] Liverpool SAB have a multi-agency hoarding protocol advising (p10) when hoarding becomes a safeguarding issue and invites the agency that identifies the issue to involve relevant partners to reduce foreseeable risks. This was ratified by member organisations (including Mersey Care) in 2019 so was pertinent to this review. It has subsequently been reviewed and updated in 2023 and is available at: https://lccdigitaloce.com/safeguarding/wp-content/uploads/2022/11/liverpool-safeguarding-adults-multi-agency-hoarding-protocol-dec-19.pdf

[33] Pregabalin is an anticonvulsant, analgesic and anxiolytic medication used to treat epilepsy, neuropathic pain, fibromyalgia, restless leg syndrome, opioid withdrawal and generalized anxiety disorder. Pregabalin also has antiallodynic properties.

'*was back with her partner and had been attending a singing and musical instrument group*. *Consideration for psychological input in the future. Further medical review to be arranged for three month's time*.' She also expressed that she was 'hopeful for the future'. In response to specific questions posed by this review, Mersey Care confirmed staff within CMHT had received suicide prevention training[34] and notes in her care records suggest pro-active consideration was given during this period to any heightened risk.

4.12 In mid-April 2022 Holly reported to police she had received unwanted, abusive contact from her ex-partner. Initially these were from his own phone, but after she had blocked his number, from withheld numbers. Sometimes the calls were silent and other times he left offensive voicemail messages; he had already called her three times that day. Holly went on to say she sent him a text message that morning telling him not to contact her again or she would involve the police, he immediately rang her back leaving another abusive voicemail message.

4.13 The police call handler asked a set of questions, designed to assess 'Threat, Harm and Risk' the combined answers resulted in her telling police he had never been physically violent towards her, but she felt he would continue with verbal abuse and may attend her property at some stage, she did not feel in immediate danger but was afraid of him.

She informed police she was suffering with her mental health and his behaviour was aggravating this, causing her stress.

[34] Mersey Care reported via their panel representative that all staff are required to complete suicide prevention awareness and clinical staff need to complete e-risk training which is assessed and competency based. All training is refreshed every three years. The Trust's Safe from Suicide Team also deliver taught sessions. Competency assessment is built into supervision frameworks for managers to check staff are skilled and understand the training. They also explained Mersey Care are working with NW suicide prevention group to address risks across the system as an active partner.

4.14 Arrangements were made for Holly to attend a police station, which she did a few days later, providing a statement outlining how the harassment started about four months previously after she ended their year long relationship due to his verbally and emotionally abusive behaviour, citing his alcohol abuse as the cause. She was supportive of police taking action and that they agreed to record her reports as a stalking crime and this was sent, in accordance with local policy, to Central Level 2 Investigations team for allocation.

4.15 The initial officer also completed a VPRF 1 that day, this serves as a referral to Liverpool City Council's Careline, if (following an internal review by the police) it is deemed to require multi-agency notification. This was forwarded to Careline 9 days later. Initially this was rated bronze but later upgraded to silver "due to stalking". The referral was screened by Careline, a RIO check was completed to establish if Holly was open to mental health services. Once it was established that she was supported by CMHT, notification should have been sent to that team. However, the Council's IMR author ascertained that, whilst a note was placed within LCC's case records in May 2022, the relevant notification was not forwarded to CMHT, so they remained unaware that a VPRF had been received. This was a missed opportunity and meant that the team supporting Holly did not have access to those notes so were not alerted at the earliest opportunity to the abuse.

4.16 Merseyside Police's central team allocated the matter to an investigating officer within 4 days, who made a note on their system acknowledging this was a matter for them to investigate.

Four days later Holly was contacted by the investigating officer to arrange for her to send evidence of the calls and messages from her phone to the Merseyside Police (NICE) link.[35] She stated she had deleted all but the last message she sent to her ex-partner (the perpetrator') telling him to leave her

[35] More information is available at: https://info.nice.com/rs/338-EJP-431/images/NICE%20Merseyside%20Police%20Case%20Study.pdf

alone. She was advised to screenshot any further messages and forward them to police on a secure link before deleting them.

4.17 Careline staff followed up the VPRF1 with a referral to Liverpool Domestic Abuse Service ['LDAS'] in early May 2022. This was good practice, according to local policy. LDAS completed a risk assessment with Holly the following week, scoring her as silver (medium risk). Earlier that week Holly had reported to her GP that her mental health was deteriorating as a consequence of the stalking. Her GP confirmed she was not experiencing any suicidal ideation or thoughts of self-harm and put her on a list for a mental health review, but it is unclear if they alerted her support worker within CMHT that she was experiencing stalking behaviours and the impact this was having on her mental health. This was a missed opportunity.

4.18 In mid-May Holly contacted police to report the perpetrator had contacted her six times that day between midnight and 6am from an unknown number, she had ignored the calls, but said they caused her stress. The investigation log was endorsed accordingly for the information of the investigating officer who told the review he was not aware of this entry. One week later the investigation officer updated the case notes, stating he had spoken to Holly and informed her he needed the screenshots before he could start the investigation. Holly provided these the following day.

According to the police IMR, he had no contact with her for the next nine days due to being on night duty and rest days afterwards, he therefore did not see notification that she had also reported to a call handler silent phone calls[36] on the investigation log until he resumed duty at the end of that month.

[36] This was recorded by the call handler who advised Holly that the investigating officer needed the screenshots. Holly stated she had forwarded them the previous day as requested. His next involvement with the case was on 05.06.22 when he left Holly a message informing her that he had submitted a request for phone analysis and he would like to discuss the case with her, the IMR author reported they could find no evidence that discussion ever took place.

4.19 Holly engaged well with two further sessions offered by LDAS in mid-May and was reportedly '*honest and open about her traumas'*. She was risk assessed again at the end of May after disclosing new incidents of domestic abuse, she scored gold (high risk). A further safety plan was discussed and completed. Holly's case was referred to Liverpool's Multi-Agency Risk Assessment Conference ['MARAC'] and Local Solutions for IDVA support. A police 'treat all calls as urgent' marker was placed for one year and she was prioritised by LDAS for counselling. This was good practice and in line with local policy. But during panel discussions consideration was given to how to improve responses so that safety plans aimed at reducing risks associated with domestic abuse also reflect legal obligations partner agencies have to work together to protect adults with care and support needs (under s42 Care Act) who, because of their care needs are less able to protect themselves. The Council reported improvements to practice in triaging VPRF so that consideration is now given by Careline staff to whether they meet the criteria under s42 Care Act so that, at this stage, duties to gather further information and commence enquiries (in line with s42(2) Care Act). This has been supported by mandatory training for all staff at level 4 of the safeguarding adults competency framework.

4.20 In May Holly contacted CMHT and spoke to a duty practitioner. She reported that she was feeling very anxious and spending most of her time in her bedroom she felt that the triggers for this was in relation to ongoing stalking incidents perpetrated by her ex-partner.

She advised that she had contacted the police and they were dealing with the abuse but reported '*dealing with the police had increased her anxiety as she had found the police as triggering*.' CMHT noted she was due for a review of her care in July 2022, but would also continue to receive input from her support worker in the interim. In discussions with her support worker Holly advised she had the support of her current partner but that this was limited as she lived on her own so only saw him 3 times a week. She also advised that she attends a local singing group which was helping with her anxiety. She was asked about the level of impact and reported she had fleeting suicidal thoughts but denied any plans or intent. CMHT case notes reported she had advised that she could

keep herself safe and if things changed and she felt like she couldn't then she would attend Royal Liverpool Hospital for a full assessment or would contact 999 in an emergency. Holly spoke with her support worker at the end of May and was given information about support groups she could join.[37] She reportedly '*chatted about her current situation with her ex-partner and that she was no longer engaged and that it had been a mutual agreement to cancel the wedding*.' Again, this indicates CMHT staff were pro-actively exploring with Holly whether there was a heightened risk of suicide.

4.21 Liverpool IDVA [Independent Domestic Violence Advocacy] service received a referral for Holly from LDAS [Liverpool domestic Violence Service] at the end of May as she had disclosed to them emotional, financial, and sexual abuse as well as coercive controlling behaviour.

LDAS had assessed her according to the MeRIT risk assessment tool as 'Gold/High Risk'. Notification was sent to the police that LDAS had referred the case to MARAC due to the 'stalking' classification and because she had disclosed abuse that was '*sexual, financial and emotional and threats to kill her*.'[38] thus raising Holly to gold status. The case was to be heard on 23.06.22. Holly was offered IDVA support which she accepted. This was good safeguarding practice, in line with local and national policy.

4.22 The following morning the allocated IDVA made phone contact with Holly. The IDVA explained their role including that IDVA was a voluntary service - independent from statutory bodies and that as client led service any support Holly might require would be tailored to meet her needs. Holly advised she had been in a relationship with the perpetrator for the last year (on and off). She advised she no longer wants to be in a relationship with him. During the contact the IDVA discussed with Holly the types of abuse she had experienced.

She confirmed verbal abuse, the threats from the alleged perpetrator and sexual abuse. She described how he would "try it on" whilst she was asleep to

[37] Albert Dock walking group and offers from the Florrie
[38] Taken from the Police chronology prepared for this review.

the point where she felt she had to 'give into' his behaviours. The IDVA discussed with Holly whether she wished to receive support from RASA, she said that she would consider their support when she 'felt ready'. IDVA discussed with Holly the safety planning already completed with LDAS. They reported, in discussions with the reviewers, that Holly seemed upbeat and explained she had told friends in her choir who were really supportive. She accepted a referral for the installation of a telecare/panic buttons and was reminded that there was a police 'treat all calls as urgent' [TAU] marker on her home. The IDVA also discussed civil remedies including application for Non-Molestation Order and court support should the police matter advance to prosecution. The IDVA did not make a referral to the police following Holly's disclosure of sexual abuse but would have been aware of the notification sent the previous day by LDAS and that her circumstances were due to be considered by MARAC panel. Had the case been discussed at MARAC, the allegations detailed in the LDAS referral would have been 'crimed' and filed pending a decision by Holly to report a complaint. The IDVA service confirmed, they would have been led by the Victim's wishes and supported Holly to report a complaint to the police if this was her wish.

4.23 The IDVA also discussed Holly's emotional wellbeing, including self-harm/suicidal thoughts Holly confirmed that she had these thoughts in the past but advised she was "okay lately trying to stay positive and busy".

Holly said that she had been taking her pain relief medication (morphine) to help her sleep and the IDVA signposted her back to GP for support/oversight. Holly stated she just wanted the perpetrator to leave her alone but confirmed she had planned activities for the coming days in the following week (Wed and Fri) and agreed to a follow up call scheduled (because of the Jubilee Bank holiday) for the 06.06.22. That afternoon, the IDVA sent Holly her contact details by text so she might store them in her phone.

4.24 The next day Holly posted a message indicating she intended to overdose. It read '*Hopefully I will be with my best friend soon. Goodbye world. Blame the stalker. Blame my ex-boyfriend I have just been arguing with and blame everyone who has abused me. Hopefully 600mls of oramorph will be enough'.*[39] A WHISC former staff member saw the message and whilst WHISC staff spoke to her, another member of staff alerted first an ambulance and, when they were unable to send a crew quickly, the police. Police were, after some time, able to gain access and persuade Holly to attend hospital. She was taken by the police to Royal Liverpool University Hospital Trust's Emergency Department ['RLUH ED']. The police submitted a further VPRF1 to Liverpool City Council in line with local policy. Police records also report an alert from a mental health worker who was off duty but noticed a suicide note posted on Facebook. Police were able to advise that she had been taken to hospital. Her family reported it was of some comfort that people intervened to support her in this way at that time.

4.25 Holly refused physical observation but confirmed she had taken the overdose at 2am. Practitioners explained that her refusal for physical examination meant they couldn't do blood tests to substantiate her level of toxicity, but they were aware of her prescriptions and likely presentations of an overdose.

The case notes also reported 'Medical staff at A+E did query whether [Holly] has taken the amount that she stated as she did not display the physical effects that would be expected.' She was monitored until 2pm. In discussion with the reviewers, practitioners explained any symptoms/ adverse reactions would normally present within 6 hours, however they allowed for a longer period in case she had only taken the overdose shortly before police attended and conveyed her to hospital. Holly remained alert throughout the 6 hours under medical observations. The declaration she was medically fit (by the RLUH ED doctor) at 2pm was to enable her to see Mental Health Liaison Team ['MHLT'] not necessarily for discharge, as this would only be determined once she had been assessed.

[39] Taken from the social media post uploaded by Holly

4.26 During that subsequent assessment by a MHLT mental health practitioner Holly expressed an inability to maintain her own safety, assessment records reported 'she feels she would make another suicide attempt should she be discharged home and reported that she felt that she required hospital admission. [Holly] stated that she does not feel able to take responsibility for her own safety at that present time with increased suicidal thoughts and a strong inclination to act on them.'

Within the assessment, risk was documented "From others: Reports she is being stalked by an ex-partner – feels anxious and threatened by this. Police are aware. Denied feeling at immediate risk of harm" and that she was engaging with the Liverpool Domestic Abuse Support.' The MHLT reported Holly was open about her personal history particularly in relation to past abusive relationships. That she explained she had been feeling increased anxiety recently reporting that her ex-partner is currently stalking her which she has reported to police and that this had been going on for several months, resulting in a notable deterioration in her mental state. She explained she now felt anxious about leaving the house and stressed at the prospect of her ex-partner harming her. Holly stated that she only came to hospital as Police had "threatened to section her" she had not wanted to receive medical treatment. She reported she had taken two 300ml bottles of Oramorph with suicidal intent and stated she was regretful the overdose had not been effective. She reported that police were alerted to her overdose as she had posted about it on face book to "say goodbye". She also reported her most recent partner has not been supportive in relation to her increased anxiety and the relationship ended last night as a result. Holly reported increased suicidal thoughts. She acknowledged some suicidal thoughts that were chronic in nature, however reported that in recent weeks these had increased and reached the point where she felt compelled to act on them the night before following the ending of her relationship. She also disclosed she lived alone with 'no family or friends that she can stay with' suggesting a lack of a key protective factor in reducing risk from further suicidal ideation.

4.27 Following intervention from MHLT, the practitioner felt she presented with contradictory responses regarding her suicidal intent. Case notes report '*At points she talked about upcoming appointments with Weight Loss Clinic and LDAS and mentioned that she had ended her relationship as she did not feel it was good for her. The mental health practitioner highlighted that that [Holly] appeared future oriented and appeared to value her life from this information however [she] remained adamant she did not feel that she could cope with her current crisis*.'[40] The practitioner reported considering an informal admission during the assessment and held a discussion with the Crisis Resolution Home Treatment Team. They were satisfied, given Holly's history of intentional overdose and apparent shift from relative stability in presentation to increased anxiety, suicidal ideation and reported overdose, 'it appears some additional support was required to monitor risk.'

Holly accepted a need for increased support but reported that CMHT did not offer sufficient support to manage her current crisis. She was referred to the Crisis Resolution Home Treatment Team ['CRHT'] and was encouraged to engage with the CRHT.[41] The practitioner noted this would promote her to take responsibility for her own safety and that Stepping Stones/inpatient admission would be constantly under review, by the CRHT. Whilst Holly was reported to have agreed to engage with CRHT, there is no evidence in the clinical record of a psychiatry doctor review, or multidisciplinary team discussion, as the usual pathway was for this to be undertaken by CRHT. Such a review should provide an opportunity for comprehensive assessment and intervention. She was subsequently discharged from MHLT's Core 24 service and the Emergency Department, though the Core 24 team submitted a referral to CRHT at 6.32pm that evening. It was noted on the case records, Holly was aware of the crisis pathway and was provided with emergency contact details. A risk assessment completed by MHLT documented the discussion and reported Holly '*denied any protective factors in her life*.' A stalking risk assessment was not completed. Her brother reported he remained concerned that she may have been left to get

[40] Taken from Mersey Care's IMR prepared for this review and Core 24 assessment made available to this review.
[41] The CRHT work as a 'hospital at home team', they also act as gatekeepers to in-patient admissions. Had the MHLT practitioner believed Holly relied an in-patient admission he would have still referred her to this team to action an assessment and admission but would likely have required they attend to complete that assessment prior to discharging her from hospital.

the bus home on her own, no friends or family were contacted but this may be because previously Holly had not agreed for practitioners to contact her family as part of any care plan. As such, her brother asked that professionals consider how someone in distress, as Holly was, travels home following attendance in A&E and that this question is always asked so, if needed, support is offered. The travel arrangements should be noted within the case notes.

4.28 The next day a CRHT worker made several calls to Holly, including two cold calls to her home, they were able to access communal areas and noted that the accommodation seemed to be staffed, but that no staff were present during visits.

When they were unable to see Holly, a note was posted through her door. It is understood that, in line with Trust policy, there is an expectation for several attempts to be made for contact. However, given her assertions to MHLT the previous day, consideration should have been given to escalation e.g., discussion at the team's MDT, escalation to team lead or contacting her landlord or the police to use their powers of entry to ascertain her wellbeing.

4.29 Instead, a further attempt was made to contact Holly by phone call the following day and, when this proved unsuccessful, the worker competed a further 'cold call' home visit at 2pm, leaving another note posted through her door.

The worker reported to Mersey Care's IMR author they planned to discuss Holly's case in a 'safety huddle' but no evidence was found during this review that this occurred. Three days after her hospital attendance, the worker reported concerns to the police as she had been unable to contact Holly following the Hospital's referral. Police officers attended at Holly's home that evening. There was no reply at the address and the officers felt there was insufficient information to force entry at that point. The police log of that visit confirms that the 'treat all calls as urgent' was still flagged at her address, but that the threat of harm by any party or level of injury was, inexplicably, reported to them as 'low'. The log reports CRHT had received a referral but does not explain that this was in response to an earlier suicide attempt. It appears the police were asked to submit a VPRF if 'able to locate' Holly but information

about how to engage her or if they should exercise powers under s17 PACE if they were unable to engage with her. The log reports the officer at the scene was aware of the previous intervention from police following her earlier overdose. At 8pm that evening, the CRHT received a phone call from the police to advise that they had carried out checks with local hospitals and attended Holly's address at 17:44. They had shouted through the letterbox but had been unable to gain access and had no powers to enter her property at this stage.

The police advised they will reattempt to contact Holly and have sent a text message and voice message to her to request contact but asked also for the CRHT to make further attempts to ascertain her welfare. Separately, the Choir organiser contacted police to alert them to her concerns that Holly had stopped replying to her texts following her hospital attendance. This practice demonstrates a lack of coordinated risk management, contrary to national and local policy and case law. As such this is addressed below in section 5.

4.30 That same day, the officer investigating the stalking allegations recorded Holly had provided a screenshot of the call logs and an application had been made to Vodaphone to identify the telephone number behind the withheld caller ID.

4.31 The following morning Merseyside Police officers forced entry to Holly's home following a concern for her safety, Holly was sadly found dead. A duty inspector attended the scene, and the matter was reported to HM Coroner. A post-mortem was carried out and the cause of death was established as morphine toxicity.

4.32 Following Holly's death, the MARAC referral which was due to be heard in late June was withdrawn. LDAS facilitator of the freedom programme also noted Holly's absence from the planned session on later that week and recorded her absence on OASIS, including a key date alert to check in on Holly regarding her welfare for the following week.

4.33 That day the investigating officer was made aware of Holly's death by his supervisory officer who had also contacted her family. They were advised of that allegations of stalking were being investigated, but there was no suggestion this was linked to her death. Whilst not within the scope of this review, participants questioned whether there are opportunities to improve practice of reporting to families whenever there is a sudden death suspected to be linked to suicide.

Panel members, specifically police and public health, confirmed they were working to amend the sudden death notification form to include a prompt to officers to offer support to family/ friends from Amparo (an agency who offer direct support to people bereaved by suicide) so that officers obtain consent to share contact details with the coroner who can then make the onward referral. The investigating officer also received the results of the phone analysis that day, showing the perpetrator had contacted Holly forty-five times between March - April 2022.[42] He circulated the suspect as wanted for the s2A stalking offence. Following an investigation review in late June 2022 by a supervising officer, the investigating officer was advised that Holly's death did not preclude the suspect from being interviewed. Arrangements were made to do so that day, but due to a system failure the interview did not take place until October 2022. The review can find no information on systems to explain why the interview did not take place for three and a half months. Her brother reported that, following her death whilst clearing her home, he had found further evidence of calls she had logged (as she had been requested to do) and that he had made extensive attempts to forward this to the investigating officer. In frustration, after visiting numerous police stations and making frequent calls, he posted a message on social media that triggered a response from the police agreeing to meet with him to retrieve the additional evidence.

[42] Until those results were available he had a list of withheld phone numbers which, in his view, was insufficient to proceed to arrest or voluntary interview of the suspect.

4.34 In October 2022 the perpetrator, under voluntary interview, refuted all allegations, saying she was the one who would not accept the end of their short relationship and continued to contact him. As he denied he had been abusive towards her he was not referred for support in this regard. MDVS explained, they work with perpetrators (including those with little or no insight into their behaviours) to help them understand the impact and move towards changes in behaviours.

MDVS have also provided training the Liaison and Diversion Service so that they can make referrals but both agencies will need the perpetrator's consent to do so. Merseyside Police are working to make positive requirements as part of civil protection orders (DAPO or SPO) once this is permissible in 2024. So, the perpetrator's denial should not have precluded the investigating officer (given the objective evidence provided by Vodaphone) from making a referral. The perpetrator also denied issues with his alcohol consumption, consequently he was not referred for alcohol support. A file of evidence prepared and submitted to a Police Decision Maker ['PDM'] who returned it later that month due to the case material not being submitted correctly, an error relating to unsigned material was the cause of this. The evidence was reviewed again two days later and sent to the Crown Prosecution Service ['CPS'] requesting a charging decision, the police proposed a charge for the offence of 'Harassment without violence (or alternatively) stalking'.[43]

4.35 In November 2022 the reviewing CPS lawyer advised that the evidence put forward by police amounted to an offence of 'Harassment without violence', under S2 of the Protection from Harassment Act 1997.[44]

Within their response they questioned why the officer believed the statutory time limit to be in December rather than October 2022. The reviewing officer wrote a week later to confirm their view that the time limit had expired for an

[43] Taken from the 1st pre-charging decision report

[44] This is a summary offence; therefore it has a six-month limit for when charges had to be laid which, on the evidence submitted, had expired.

offence of Harassment without Violence. No decision regarding whether the evidence met the Full Code Test[45] was recorded.

They also confirmed the only potential alternative offences (e.g., malicious communications) were also subject of a six-month statute of limitations. The file was returned to police, with a reminder of their powers to recommend no further action in this instance.[46] No specific alternative offences were recorded by the reviewing lawyer.

4.36. Prior to that further communication, the investigating officer sent an email to Holly's brother on the informing him of the outcome of the case, stating delay in submitting a file to CPS was partly due to Holly's unexpected death which prevented him from gathering additional evidence from her. He did not elaborate further in the message as to what he intended to gather, and the review can find no evidence on police systems to indicate his intention to do so, or what evidence he was referring to.

4.36 The investigating officer made a further submission to the reviewing lawyer two days after he had written to Holly's brother stating that he considered the latest incident meant the expiry date was December 2022 not October 2022 as '*the last communication from the suspect to the IP was the [early] June 2022 and this is documented in exhibit AS02, page 30, call log18*'.[47]

This referred to a phone report produced from Holly's phone which documented the call. The reviewing lawyer appears to have misunderstood and thought the officer was referring to the handwritten log of contact found at Holly's address after her death, which the reviewing lawyer considered to be inadmissible to evidence any contact that was not referenced in Holly's statement. There is no specific reference made by the reviewing lawyer to the phone report extracted

[45] CPS's 'Charging (The Director Guidance) 6th edition, published Dec.'20 (available at https://www.cps.gov.uk/legal-guidance/charging-directors-guidance-sixth-edition-december-2020-incorporating-national-file) explains that when police request a charging decision. A Full Code test decision was never recorded by the reviewing lawyer as she took the view that the statutory time limit had expired for a charge under S2 Protection from Harassment Act or any other summary only offence.
[46] The DPP Guidance on Charging states that the police have the power to take no further action in any case in which the evidential test is not passed
[47] Taken from the 4th pre-charging decision report

from Holly's phone and so it is not clear whether they considered the evidence that a call had been made by the perpetrator to Holly in June.

In early December 2022 the CPS replied stating the evidence (handwritten log) was not admissible for the reasons already outlined, and there was no mention of it in Holly's statement of complaint so this would have caused legal issue attributing this within a criminal trial. They confirmed the time limitation of 6 months had expired, so reminded the officer to exercise their powers. The following day, the PDM forwarded a finalisation notice to CPS informing them the matter had been closed and the suspect had been informed no further action would be taken against him. The investigating officer also wrote to all parties a few days later to inform them that no further action would be taken.

5 Overview

5.1 Holly experienced high levels of harassment from her former partner. There is objective evidence from her phone analysis that was available to the police in June 2022, showed the perpetrator had contacted Holly 45 times between 08.03.22 and 15.04.22. This amounted to a course of conduct that objectively met the definition of stalking. Before her death, specialist practitioners from domestic abuse services had recognised this and provided practical and emotional support, but this review has found poor inter-agency communication contributed to delays in progressing the criminal investigation. Too little consideration was given across partner agencies as to what adjustments would be needed by services to support her to stay safe and pursue the perpetrator. Partners did not have established ways (outside of the MARAC process) to pull together a whole system approach, so Holly's mental health support and the police investigation continued to operate in silo.

5.2 Holly died during the 10 weeks interval between her disclosure of the abuse to the police to the matter being heard at MARAC.

She was known to agencies as a resilient, intelligent, and emotionally insightful woman who had previously responded well to volunteering opportunities and social activities designed to help her manage symptoms of EUPD and anxiety. At the time of her death there was no clear plan that limited contact by her perpetrator, held him to account for his actions and (in accordance with the Victim's code)[48] put her needs first. This did not happen.

5.3 Reassuringly, the officer initially recording her concerns recognised her vulnerability and alerted Careline. In addition, Careline staff recognised her experiences amounted to domestic abuse and referred for specialist support to LDAS. However, the VPRF1 was not recorded as a safeguarding concern so information gathering was not undertaken to consider if Holly was an adult at risk as defined by the Care Act 2014. Improvements to practice (noted within 3.22) will have a wider impact if all partners respond positively to requests for multi-agency strategy discussions and information gathering. For Holly, this could have included a discussion with her to understand the concerns, consider her options for support and her desired outcomes. It should have also included a multi-agency discussion and risk assessment involving the police, domestic abuse specialists and health partners involved in her care to ensure that appropriate support and safety planning was in place, including actions for the police and the third sector to offer support to the perpetrator and thereafter hold him to account if his behaviour persisted.

6 Analysis

6.1 The Partnership and Health and Wellbeing Board have declared a firm commitment to work towards zero suicides in Liverpool. Mersey Care, working alongside LCC's public health team and the Zero Suicide Alliance, have introduced policy and training initiatives seeking to achieve this goal.

[48] The Code of Practice for Victims of Crime in England and Wales, sets out the minimum standards that organisations must provide to victims of crime. It is issued by the Secretary of State for Justice and available at: https://www.gov.uk/government/publications/the-code-of-practice-for-victims-of-crime/code-of-practice-for-victims-of-crime-in-england-and-wales-victims-code

Holly's experience, however, lay bare the continued barriers to interagency working and gaps in services to achieve those shared aspirations, particularly for Liverpool residents at high risk from stalking and harassment from 'connected person'. This section examines how and why events occurred, what information that was shared, the decisions that were made and the actions that were taken or not taken. We have grouped these according to the key lines of enquiry, highlighting good practice as well as opportunities to improve practice.

KLOE 1: Following disclosure in April 2022 by Holly of the frequent, abusive contact from her ex-partner to the Police, was appropriate action taken by police to gather evidence in line with expected standards.

6.2 The police call handler and initial officer who met with Holly in April 2022 asked relevant questions to complete a risk assessment. The investigating officer did not complete a stalking checklist as the Police decision maker had submitted the case to the CPS for consideration of the 'Harassment without violence' offence. A National protocol[49] promotes the use of the Joint NPCC and CPS Stalking or Harassment Evidence Checklist (the Checklist), but this is currently under pilot and Merseyside Police are awaiting ratification and roll out of the final version before this will be implemented. The initial police officer also drew up a two-page statement with Holly indicating the type and level of contact, as well as the impact this was having on her. Holly reported the contacts were causing her stress (and this was described on the investigation log), the officer recorded a crime of stalking, (s2A). Holly confirmed she was not in fear of violence from the perpetrator, but that it was causing her stress. The decision to report it as a s2A offence was in line with Home Office Crime reporting requirements, which advises officers to log such reports as stalking, whenever the perpetrator and victim have been in an intimate relationship and the perpetrator is over 16.

[49] NPCC and CPS Protocol on the appropriate handling of stalking or harassment offenses.

This is even if, on balance, the officers believe it may not meet the definition of stalking (under s2A or 4A). As officers are trained to initially record for the most serious offence and 'work backwards' when collecting evidence. The officer also, in compliance with local multi-agency safeguarding policies, completed and submitted a VPRF1 in respect of Holly thereby evidencing he had considered her needs as a vulnerable victim. The officer had also asked relevant questions to ascertain from Holly that she believed his abusive behaviours were associated with alcohol misuse. This was good practice.

6.3 The officers attending Holly's home to complete a welfare check in early June 2022 (when the first concern that she may have taken an overdose was raised) also submitted a VRPF1.

Sadly, it is likely that she had already passed away before that referral would have been processed and forwarded to LCC's Careline to consider if there were safeguarding risks. In discussions with reviewers, practitioners explained they receive up to 350 VPRF1s each month and that not all will require a safeguarding response. For example, where adults are already in receipt of support from LCC's adult social care teams or Mersey Care's CMHT or crisis teams those notifications should routinely be forwarded to the relevant team to inform ongoing care plans. As noted above, failure by Careline to forward this notification to the CMHT in April 2022 delayed that team from taking this into consideration, however Holly disclosed the abuse and its impact directly to the team in May 2022. Within their response to this review LCC confirmed there is now agreement for Careline staff to have direct access to RiO case notes (the electronic patient records used by Mersey Care) so, once staff have completed training, this will enable information from VPRF1 to be shared far quicker with mental health practitioners. The police also advised they have revised the VPRF1 form to include questions both the victim's and perpetrator's mental health status.

6.4 Thereafter the case was allocated to an investigation team. The joint protocol requires that in 'cases involving stalking or harassment, the range of alleged offending behaviour, with particular reference to other crimes, must be considered. *This can include but is not limited to digitally enabled crime, criminal damage, and malicious communications*.' [p.3.5] It further requires that risk identification tools (such as Domestic Abuse, Stalking and Honour Based Violence risk assessment or SASH[50] are completed) and *'it is essential that complainants are asked if they have altered their behaviour (even in subtle ways) in response to the alleged behaviour or activities.' [p3.9]*

Merseyside police reported they use the MERIT risk tool and confirmed gthat this had been completed by LDAS staff (as noted above at 4.22).

6.5 The risk to Holly was assessed by a supervisory police officer as medium based on the original information, thereafter (in line with standard procedure) the supervisor devised an investigation plan for the allocated investigating officer to follow.

After Holly contacted police again following further contact from the perpetrator, there is no evidence that further statements were taken from her, so the fear/distress element was not later conveyed to the CPS in a format that would have been admissible within criminal proceedings. As per force policy, the investigation underwent periodic supervisor reviews on four occasions and assessment by a police decision maker prior to the file being submitted to the CPS, the review can find no evidence that the investigating officer considered alternative offences (such as harassment or malicious communications). The investigating officer explained[51] he did not consider alternative offences of harassment or malicious communications, based on the information he received prior to the death of Holly as he was satisfied that stalking was the appropriate offence.[52] However, it would have been clear (from input provided

[50] https://www.stalkingriskprofile.com/stalking-risk-profile/sash

[51] Taken from the Police's IMR prepared for this review

[52] The offence of Stalking with fear of violence is triable either way, whereas harassment or malicious communications are summary offences, both carry a six month limitation from the date of the last offence. Had either of the above offences been proposed from the outset, the internal police review concluded it is possible evidence could have been presented to the CPS within the required timescale.

by the police decision maker) that they did not believe the evidence met the threshold for the stalking offence. Better practice, therefore, would have been for the officer to record why he did not consider alternative offences, as this is what is required under the joint protocol. He further stated he considered the risk posed by the perpetrator was low to medium as no physical approach had been made. Given such a rationale, it seems remarkable that consideration wasn't given to alternative offences and the strict time limits that would have applied to initiating criminal proceedings under s2 of the Protection from Harassment Act.

6.6 The police's internal review also identified an issue as the investigating officer was unaware of Holly's first suicide attempt until after her death and the content of the suicide note in which Holly attributed the distress from stalking for her attempt to end her life.

Had that been picked up by the officer it would surely have signalled a significant deterioration in her mental health and her diminishing ability to ignore the contacts from the perpetrator, thereby identifying that her needs as a victim had increased. The attempted suicide incident generated an occurrence on Niche,[53] which the investigating officer did not notice, conversely the existing investigation into stalking was not seen by whoever inputted information onto the police system following Holly's suicide attempt. Good practice would be for investigating officers to interrogate Niche on a regular basis to ensure no new incidents (that might impact on their ongoing investigations) have been recorded involving victims or perpetrators. They noted, however, that the Daily Summary circulated across the force did not include an account of police attendance at Holly's home, this is not unusual when the subject is taken to hospital and the immediate outcome is a positive one.

[53] Niche is a police records management system used by several UK police forces. It manages information in relation to the core policing entities of people, locations, vehicles, organisations (businesses or other groups), incidents (or occurrences) and property/evidence.

6.7 It was not possible to meet with any officers involved directly with this case due to the ongoing IOPC investigation, so not possible to ascertain why it was so difficult for Holly's brother to forward further evidence of additional contacts (recorded by Holly prior to her death) to the investigating officer. There is no explanation for why evidence, including further witness statements from Holly, were not secured in a timely manner.

6.8 In discussions with the reviewer, practitioners and senior managers felt that whenever a criminal investigation involves a victim with ongoing care and support needs that could be impacted by the criminal process, officers should pro-actively seek agreement from the victim to engage with their wider professional support network to better implement the Victim's Code for Policing.[54] Holly's family also advocated for better coordination across different statutory expertise is needed.

This could be achieved by more closely aligning the criminal investigative process to safeguarding duties (under s42 Care Act) also owed by police so that officers become more confident to call multi-disciplinary meetings to better understand how to support victims, including whilst early enquiries or evidence gathering is required prior to any action against perpetrators. There is now a well-established evidence base[55] that victims are at greatest risk of death or serious violence where stalking and/or coercive, controlling behaviours are a factor with one study reporting a 9 fold increase in risk if the victim left or did not return to the perpetrator.[56] Another UK study identified a rise in domestic abuse victim suicides in 2021-22 and noted a key factor in that rise was

[54] Published by the College of Policing in March 2021 and in force during the review period. It is available at: https://www.college.police.uk/guidance/victims-code/victims-rights-policing

[55] For example, see Flowers C, Winder B, Slade K. "You Want to Catch the Biggest Thing Going in the Ocean": A Qualitative Analysis of Intimate Partner Stalking. J Interpers Violence. 2022 Apr;37(7-8):NP4278-NP4314. doi: 10.1177/0886260520958632. Epub 2020 Sep 17. PMID: 32942925; PMCID: PMC8980455. https://eprints.glos.ac.uk/4553/1/NSAW%20Report%2004.17%20-%20finalsmall.pdf

[56] McFarlane et al, 'Intimate partner stalking and femicide: urgent implications for women's safety', 2002 available at:

https://doi.org/10.1002/bsl.477

breaches of protective orders suggesting an impact for victims of a perception there is a lack of enforcement or accountability for perpetrators.[57]

Practitioners involved in this review highlighted the need for multi-agency policies to also address increased risks of self-harm and suicide directly during this period and for officers therefore to, as part of the early stages of an investigation, complete the relevant risk assessments and agree a safety plan (which should include access to early intervention support) with the adult at risk and their wider professional support network.

6.9 The Victim's Code (specifically right 4) requires police officers and staff to employ trauma-informed practice and conduct a victim's needs assessment to inform if the victim may be eligible for enhanced rights. This also requires officers to 'take responsibility and instigate referrals… share information with other agencies so the victim doesn't need to repeat themselves.'

Her ability to stay safe was considered and referrals made to LDAS, but greater consideration of police powers to disrupt her perpetrator may have validated her experience. This is important, given her disclosure of severe and enduring mental ill-health and the adverse impact that the on-going abusive contact was having. Specialist domestic abuse practitioners confirmed that, had a shared risk management plan been agreed and included their dedicated resource to support stalking victims, this could have discussed a safety plan with Holly much earlier and supported her to gather and report further evidence of the offences safely. An earlier multi-agency discussion would have validated Holly's concerns and could have alleviated her growing sense of hopelessness, which was a key factor in her suicide. The intersectionality of the impact on her resilience and ability to stay safe was explored only by those providing IDVA and domestic abuse services. Statutory partners risk assessments had not considered the psychological impact or heightened risks of intimate partner

[57] Vulnerability Knowledge and Practice Programme Year 2 report, Home Office and NPCC, 2022 available at: https://www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

violence or suicide, despite national research identifying many of the factors in this case as elevating the risks.

6.10 LCC's public health team and Mersey Care's 'safe from suicide' team reported they have designed free training and awareness materials which should be widely disseminated to improve identification of elevated risk and a more coordinated response from the point of first disclosure by a victim.

KLOE 2: Is the distinction between offences under the Protection for Harassment Act 1997 understood by relevant partners in Liverpool?

6.11 The distinction between the different offences (detailed above at 2.8-2.11) is important because of the limitation period attributable to the summary only offences of stalking (section 2A) and harassment (section 2). These carry the maximum sentence of six months. In such a case, perpetrators must be charged within 6 months from the date of the last incident comprising the course of conduct: Director of Public Prosecutions v Baker [2004] EWHC 2782 (Admin)

6.12 For offences triable either-way of stalking (2A), causing fear of violence or serious alarm/distress which has a substantial adverse impact on the victim's usual day-to-day activities (4A) and harassment causing fear of violence (section 4) there is no such limitation. These carry a maximum of ten years' imprisonment and/or a fine on indictment.

6.13 Whilst anyone experiencing a conduct which could amount to harassment or stalking is entitled to seek civil or criminal redress through powers under the PHA 1997, Domestic Abuse Act 2021 or Family Law Act 2006, the Stalking Protection Act 2019 was introduced to close the gap in existing protective order regime so that even where the threshold to commence criminal prosecutions isn't met, police would have powers to intervene early in stalking cases. The statutory guidance[58] that accompanied this Act came into effect on the 20.01.20 so would have been appliable during the review period.

6.14 Stalking Protection Orders (SPOs), introduced in England and Wales, signify a shift from purely punitive measures to a more comprehensive approach that prioritises victim safety and offender rehabilitation.

Pre-emptive safeguarding is critical for stalking victims, and SPOs focus on that early intervention, by stepping in at the emerging stages of stalking, i.e., menacing, unwanted phone calls late at night. The flexibility of SPOs to impose specific restrictions on the perpetrator, i.e., prohibiting contact, restricting physical proximity can offer the victim immediate relief and security. SPOs are also a further opportunity to impose a requirement for the perpetrator to undertake a treatment programme and facilitate behavioural change, benefiting the victim, the perpetrator, and the wider community. Most importantly, these safety measures can increase the victim's confidence in a criminal justice system that is designed to keep them safe.

[58] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951354/SPOs_statutory_guidance_English_with_changes__002_.pdf (accessed 16.07.23). See also guidance from the College of Policing on effective responses to reports of stalking or harassment available at: https://library.college.police.uk/docs/college-of-policing/Stalking-and-Harassment-2020.pdf (access 16.07.23)

6.15 Stalking is a serious issue that has profound consequences for its victims, both emotionally and psychologically. However, ambiguity and a lack of clear definitions surrounding the term can sometimes pose challenges for professionals in determining whether certain actions, such as receiving unwanted calls late at night, qualify as stalking or not. Professionals are expected to consider the intensity, frequency, nature of the interaction and perception of threat and compare this to other behaviours.

6.16 Understandably, practitioners involved in this review (including those with specialist expertise in supporting victims of stalking) felt it was correct to validate with Holly the abuse she was experiencing and were sympathetic to the conclusion reached by the police that the abuse amounted to stalking offence due to nature of the contact, time calls were made (usually late at night or in the night, such that they would disturb Holly's sleep) and the frequency which would have amounted to a course of conduct. They highlighted that, because the perpetrator had known Holly for a long time and been in a relationship with her for over a year, he would have been aware of the likely adverse impact that his behaviours were having on her mental health.

Those with expertise in support victims of domestic abuse, particularly coercive and controlling or stalking behaviours felt too little regard was placed by the investigating officer on the first aspect of the second limb of the offence (namely a fear of violence) and insufficient regard was had to the adverse impact this had on Holly's day-to-day activities. Panel members felt it was important to highlight that minimising a victim's experience can further traumatise the victim and make them feel isolated, helpless and less likely to seek help in future. While unwanted late-night calls can certainly be a form of stalking and have a significant negative impact on the victim, they accepted ambiguities in definitions, perceptions of threat, and the nature of the interactions can sometimes lead professionals to underestimate or misinterpret the gravity of the situation. They advocated for continuous training as an essential component to practice to ensure that such behaviours are consistently recognised as the serious issues they are.

6.17 They also spoke of how Holly's own strength of character may have given a false impression of her ability to withstand ongoing abuse on top of the chronic pain, co-occurring depressive and hoarding issues and social isolation. Understandably, officers will be guided by what victims report the impact is on them, but this case demonstrates the importance of bringing together the 'team around the person' to get a more holistic understanding of the likely impact and how additional distress caused by harassment or stalking can escalate very quickly with devasting consequences. Whilst she was clear that she did not want to give the perpetrator power, she disclosed the abuse and its adverse impacts to numerous professionals, including her GP, CMHT duty worker and support worker, hospital staff, police and domestic abuse practitioners. She also confirmed she found reporting the matter to the police triggering and that she was struggling to utilise the techniques to manage the symptoms of her EUPD in May 2022. This information was not reported to the police. The onus, as is made clear within the Victim Code, is not on victims to do this.

6.18 MDVS have an Independent Stalking Advocacy support worker within their team in recognition of the complexities for victims to evidence what they are experiencing is an offense.

Panel members explained that with this form of abuse, perpetrators often escalated their behaviours if left unchallenged. Their behaviours are also usually insidious, so it isn't always straightforward for victims to report or to know what to be aware of so as to keep themselves safe. For this reason, they support worker acts as a vital link to ensure the victim's experienced is understood by police and that, in turn, the victim can be reassured that police and relevant partners are using all available powers to discourage the abuser.

6.19 They spoke of the need to learn from good practice tackling other forms of exploitation, where police and agencies work together to pro-actively disrupt abusive behaviours even if the threshold for a criminal charge has not been reached. This, they explained, is the purpose behind Stalking Prevention Orders ['SPO'] but Home Office data reported Merseyside Police had not applied for a single order between Feb '20- Dec '21. Most review panel members were not aware of any SPOs made subsequently, though the Force Policy Strategy Unit confirmed that, to date, 7 SPOs have now been made. Every application has been successfully granted. A review of the new powers reported most respondents felt SPOs were effective in reducing the risks of stalking- 78% of police respondents and 61% of legal advisors and that victims have welcomed the additional protection provided by SPOs.[59] Of relevance to this review, the report explained '*the criminal standard of proof which must be met for certain parts of applications for SPOs does not seem to be preventing them from being granted. The data we received from HMCTS shows that SPO cases have a very high grant rate at the magistrates' court. Between the period 20 January 2020 and 19 January 2021 there were 363 cases concluded relating to SPOs, of which 284 (78%) were granted and 19 (5%) were refused*'.

6.20 There is a perception among participants in this review, that police officers refer cases to national charities, but do not make use of local services to address stalking behaviours.

This is due to a lack of established local pathways and something which (subject to resources) the police would like to develop. Because it is rare for cases to reach the threshold for a response at national level, this practice results in hidden victims and a loss, locally, of intelligence about perpetrators. Reliance only on national support agencies also makes it much less likely that information regarding risk will be shared with the victim's local professional network to formulate a practical multi-agency shared risk plan.

[59] Taken from the Court Service and Home office joint review, published January 2023 and available at: https://www.gov.uk/government/publications/management-information-stalking-protection-orders/review-of-stalking-protection-orders-accessible-version#summary-of-findings

6.21 Equally participants believed there was overreliance within Merseyside Police for restraining orders, but wished to take this opportunity to highlight SPOs provides additional powers to gather evidence pro-actively without placing undue burden on the victim e.g., by monitoring perpetrators calls. The joint Courts and Home Office review concluded there was a training need, as police respondents reported 'some courts prefer using bail conditions and other protective orders rather than granting SPOs and some mentioned that judges are more reluctant to impose positive requirements.' That review recommended contacting Chief Constables for any force who have applied for less than 5 SPOs, participants in this review commented that senior leaders within the Force now appear to be keen to promote greater use of SPOs.

KLOE 3: Were stalking risk assessments completed by agencies following Holly's disclosure of the contacts and the impact this was having on her mental wellbeing?

6.22 As noted above, the investigating police officer did not complete stalking risk assessments in line with expected practice and the national stalking protocol, but this had already been completed by the first officers who had taken details directly from Holly and reported to Careline within the VPRF1.

6.23 LCC's Careline missed an opportunity when they received the VPRF1 in April 2022 to identify Holly as an 'adult at risk'[60] and decide what action was required and by whom to prevent abuse, including any risk of domestic abuse.

Within LCC's IMR they accepted there were missed opportunities as they would have expected a clear rationale from the qualified social worker screening the VPRF1 if they did not believe it met the threshold under s42 and, even then, set out any additional actions required to reduce risk. They accepted this wasn't recorded on Holly's records. However, Careline staff did refer the matter to LDAS, indicating they are recognising domestic abuse requires that specialist response. In discussion practitioners queried whether Holly would have been viewed by Careline staff as having care and support needs, as this

[60] The term used within s42 Care Act 2014 to identify when additional duties are owed to carry out an enquiry to protect an adult with care and support needs experiencing abuse.

was often very focused on the need for practical support to manage day to day activities due to frailty. In their experience, they felt people with needs associated with mental health conditions were not seen as falling within the definition of 'adult at risk'. For the avoidance of doubt, s42 safeguarding adult's duties arise if an adult is unable to protect themselves from abuse due to any care and support needs, including mental health.

6.24 LCC confirmed, following their internal review, they have created a checklist for screening staff to highlight when safeguarding duties will apply, they have also provided additional training and guidance to staff setting out next steps even if the s42 thresholds are not met. This includes prompts to consider whether the adult at risk is subject to coercion or controlling behaviours. It also asks specific questions to ascertain if the adult has any mental health conditions. In addition, senior managers reported they have conducted audits of matters that had been screened as requiring 'no further action' and, where necessary, reopened any cases- reinvestigating or making further contact with the adult at risk and their professional or wider support network.

6.25 LCC also explained they were revisiting with police colleague the process for VPRF1 forms to make it easier for professional coordination. Given the requirement within the Victim's Code, LCC and Merseyside police should ensure that any revised process is designed with a trauma-informed approach so that contact with the victim is coordinated and they are not required to repeat events to numerous professionals.

Consideration also needs to be given to how to share information from VPRFs with the adult's GP who often holds key information pertinent to any enquiry but can also use the information to inform care plans and risk assessments, enabling onward referrals to secondary mental health to be fully informed.

6.26 Panel members and senior managers from across partner agencies explained that, following extensive training, their staff knew to submit a referral to Careline if safeguarding concerns arise, because of the statutory duties for relevant partners to cooperate and conduct an enquiry. They explained that the MARAM process was introduced to enable any practitioners from all disciplines to call a multi-agency meeting to address risks for adults who may not meet the criteria for a s42 enquiries, but are who are or may be at risk, for example, risks carers may face or low/ medium hoarders or those who are very socially isolated. If necessary, this can enable more senior managerial oversight of high-risk matters.[61] They wished for this review to reiterate that it was for anyone calling a MARAM or making a referral to Careline to follow up if not had a response.

6.27 Referral to Careline should not be viewed as a handover of responsibility, rather an opportunity to collectively safeguard across partner agencies where that would bring benefits for the adult. For some agencies however, particularly emergency responders (as their own organisational practice is predicated on handing over to other services if the issue can't be resolved at the initial contact) it can be difficult to ensure that continuity. Emergency responders, GPs or third sector organisations explained it isn't always easy for them to ascertain if either the s42 or MARAM processes are underway.

6.28 GP and hospital staff explained that whilst they do have mechanisms for placing alerts of electronic case files for patients if there are safeguarding risks or additional needs requiring reasonable adjustments to provide equitable care, they are not routinely invited to s42 strategy meetings even for patients well known to them.

Whilst in the past it may not have been easy for GP to attend, the increased use of online platforms for meetings means it should be easier to secure their attendance. Holly's GP highlighted that their surgeries have resources (including safeguarding leads and mental health practitioners) that could have supported her and other partner agencies address the escalating risks linked to

[61] The policy document that explains the purpose of MARAM process is available at: https://lccdigitaloce.com/safeguarding/wp-content/uploads/2022/11/MARAM-Process-FINAL.pdf

the abuse she was experiencing, but to offer this they need to be included in those early discussions.

6.29 There is also no evidence that a stalking risk assessment was completed on either occasions that Holly discussed the abuse with her CMHT team in May 2022. In conversation with the reviewers, those involved in the discussions accepted this mirrored the lack of professional curiosity exhibited when Holly raised the impact of her isolation during the Covid lockdowns, her requests for reviews and further assistance during 2021 and also when the extent of her hoarding became apparent. This was a critical missed opportunity as research had reported the adverse impact Covid lockdowns had in respect of increased victimisation and making it harder (due to delays within the criminal justice system) to hold perpetrators to account.[62]

6.30 It does not appear it is standard practice for patients, their advocates, or their GPs to be routinely invited to CMHT's multi-disciplinary meetings.

Nor is there any evidence that staff within CMHT contacted Mersey care's Personality Disorder hub to seek expert advice on alternative therapeutic options, which seems surprising given professionals' views that she was not likely to benefit from any additional medication to address her worsening symptoms, including elevated risk of self-harm.

6.31 It is important to note that, at no time prior to or during the review period did Holly meet the criteria for the Care Programme Approach ['CPA'], so did not have an allocated Care Coordinator.[63]

In response to issues arising from this review, Merseycare confirmed that it has undertaken a comprehensive review of the Care Programme Approach and are

[62] Bracewell K, Hargreaves P, Stanley N. The Consequences of the COVID-19 Lockdown on Stalking Victimisation. J Fam Violence. 2022;37(6):951-957. doi: 10.1007/s10896-020-00201-0. Epub 2020 Sep 10. PMID: 32934437; PMCID: PMC7483056.

[63] The PD policy (Clinical guidelines) states "All service users with borderline personality disorder on CPA should have an Extended Care Plan completed if they reach the threshold of (a) having single/multiple admissions totalling 30 days in psychiatric hospital a year (b) a request for consultation from the PD Hub Service for complex service users is made"

in the process of implementing a new framework for care of mental health patients under the Community Mental Health Framework.[64]

The Trust explained "we want to drive a renewed focus on people living in their communities with a range of long-term severe mental illnesses, and a new focus on people whose needs are deemed too severe for Improving Access to Psychological Therapies (IAPT) services but not severe enough to meet secondary care "thresholds", including, for example, eating disorders and complex mental health difficulties associated with a diagnosis of "personality disorder". For Mersey Care, key changes will be a move away from the use of a two-tier system such as CPA/non-CPA. They reported they are moving to a position whereby all service users subject to non-CPA currently, as Holly was, will have a key link worker and a set review period. Personalised care plans will be integral to service delivery with a focus on intervention-based care. They intend to strengthen links to community/voluntary sector in and out of the teams. Agencies have been commissioned to work with the Trust to key work non-CPA service users. Given the high numbers of non-CPA open to mental health services a robust plan is in situ, with a Standard Operational Procedure expected to come into force before the end of 2023. Going forward, this should mean that adults diagnosed with personality disorders should all equally benefit from Mersey Care's Personality Disorder policy[65] with treatment plans delivered via Structured Clinical Management set out within an extended care plan.

6.32 Mersey care's personality disorder policy warns *'historically, service users with BPD[66] have been excluded from receiving mental health services, and a negative attitude still remains for some professionals.*

This in turn greatly affects any therapeutic alliance and engagement in collaborative working. To overcome this, the Trust advocate for:

[64] As put forward by NHS England in the Framework published in 2019, available at: https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

[65] Mersey Care NHS Trust's Personality Disorder policy, Policy number LOC024, revised in May 2021

[66] 'BPD' or Borderline personality disorder is another term used for Emotional Unstable Personality Disorder

Continuity and consistency of approach: Given the high risk with this service user group for patterns of escalating action and reaction, consistency between different teams, staff within the same team and between a professional and service user are essential. Hence, it is critical that there is a shared plan, including a formulation to inform the team's understanding of each individual service user.

Attending to individual countertransference feelings: Working with service users with BPD often leaves the professionals and teams involved with strong feelings (both positive and negative). For example, commonly staff can find themselves feeling powerfully protective/caring or rejecting/critical in relation to service users with BPD. Processing these feelings in a professional manner is important in maintaining appropriately professional interactions. This both protects service users from harm but also ensures that the "caring system" does not become hopeless, pessimistic and risk averse.

Understanding organisation anxiety and defences: Teams working with service users with BPD sometimes find themselves feeling "stuck" in clinical dilemmas and uncertain about how best to proceed. This can manifest itself as extreme ambivalence from the clinical team towards the particular service user, who then is at risk of "malignant alienation" (Watts 1994) from the staff team. This commonly happens during inpatient admissions, during which time service users can present with an intense and confusing paradox of emotions: feeling contained by being in a supportive environment and not wanting to be discharged, whilst simultaneously feeling claustrophobic and agitated about the restrictive environment on the ward and expressing a wish to leave and harm themselves. This can lead to an escalating spiral of threats, acts of self-harm and violence, with the mental distress within the service user becoming translated into anxiety within the care system…

Formulations (biopsychosocial): should be at the centre of care, co-created with service users, and drawing upon psychological models. Medication: can offer symptomatic relief but due to (1) a lack of evidence that it can effectively change the disorder itself (2) the risks associated with polypharmacy and (3)

because it can promote the “sick role” and reduces personal agency, the role of medication should not be the most prominent part of care.’

6.33 The policy advises ‘effective recovery for people with BPD requires a careful balance between encouraging the service user to take responsibility for change, owning the consequences of their own behaviour and offering support and intervention when needed. Achieving this balance is not easy and cannot be reduced to a simple set of rules. ... Of particular importance is the need for clinicians to feel supported in taking clinically indicated risks, especially around reducing admissions to hospital. This is important; although admissions to hospital might reduce risk in the short term, often they have a counter-therapeutic effect fostering dependency and causing further harm by increasing the long-term risk. In turn it is hoped that service users with BPD will then feel more contained themselves, through *their experience of receiving care that is more integrated and cohesive, which in itself might reduce the need for admission to hospital.*’[67]

6.34 A core principle within the policy is to seek to reduce in-patient admission by providing relational continuity as the ‘quality of therapeutic alliance is key to promoting growth and minimising admissions.’ The policy sets out the role of specific teams:

- CMHTs will provide the majority of care to most of service users with EUPD, but as with any tier 2 service can seek further support from the Tier 3 PD hub in Spring house.
- CRHT will act as gatekeepers to Inpatient units and aim to provide short crisis admissions for service users who are well known and guidance on the management of these is these is offered.
- Psychotherapy offers specific therapy for EUPD, as well as training and consultation to teams.

[67] Mersey Care Personality Disorder policy, revised in May 2021

- The PD Case Management Team offer 100 weeks of intensive support to those service users with the most complex presentations. In addition, the PD Hub with its combined Day and Safe service offer structured activities and support in crisis.

6.35 Within this context and the implementation by Merseycare of the National Community Mental Health framework, it is noteworthy that case notes made available to this review rely heavily on oversight by the consultant psychiatrist during three monthly reviews, whilst all other contacts from her were managed by a duty worker.

Whilst there is evidence that safety plans were checked and Holly encouraged to apply learned techniques to address her anxiety and self-harming ideation, so as to avoid admission, it is hard to get a sense from those case notes of her strengths, preferences, triggers etc. The continuity of care required to develop a strong therapeutic relationship was not apparent. Nor was it clear how her GP or support worker influenced the plan, including when the GP raised concerns regarding polypharmacy. It is hoped that, whilst redesigning the new CMHT offer for those with enduring personality disorders, learning from this case will be considered.

6.36 Mersey Care's IMR acknowledged 'service delivery to Holly was impacted increased demand within mental health services, likely influenced by the overall impact of the pandemic on people's mental health… Since the reviewed timeframe, the Trust reported its workforce has received increased support from the Safeguarding Team.

This support includes the establishment of a Trust-wide Safeguarding Duty Hub, the provision of a Safeguarding Training Brochure offering modular training on safeguarding adults and children, changes to Internal Safeguarding Reporting Procedures to incorporate a chronology of safeguarding concerns within the patient record and the implementation of formal safeguarding supervision for all staff. These measures aim to enhance the Trust's ability to identify and respond to safeguarding issues effectively.'

6.37 Between April 21- April 22 Holly had 39 contacts with her GP and staff from the practice reported she had a positive relationship with them. They explained it was not uncommon to have to manage co-occurring conditions where people report chronic pain. Often (though not a feature for Holly) they will be aware of the risk that patients might trade medication with a street value. They are also aware of the long waiting lists for specialist pain consultants and the impact that this may have on anyone's mental wellbeing. Treatment options are more complicated if (like Holly) patients have enduring mental health conditions and are facing external, additional stress or coercion. During conversations, practitioners explained this would be a good example for when the GP may wish to call for a multi-disciplinary meeting or, if that was unsuccessful in reducing risks, consider s42 safeguarding powers or the MARAM process. Her GP practice explained they now hold regular meeting to discuss the 'vulnerable patients' within their GP network and could take this opportunity to raise concerns if a patient disclosed harassment/stalking. Her practice confirmed they did speak to her frequently during this period about using techniques such as distraction strategies. But were unaware they could call a multi-disciplinary meeting.

They welcomed this is now opened to them and felt this should empower GP practice staff to call mental health teams (rather than rely on patients to initiate this contact) so that there was a more cohesive approach between primary and secondary care. Domestic abuse experts reported, in response to recommendations from a previous DHR report, they had worked with primary care networks to embed a domestic abuse champion in GP surgeries. Initially the pilot looked to support over 89 practices in Liverpool and, prior to the pilot's funding ceasing, they were able to train 11 champions, covering 4/9th of the primary care networks.[68] The champions are able to draw directly on expertise from the high risk IDVA team. The value of those champions was reinforced by RLUH staff who spoke with obvious pride in the support they receive from their

[68] The 'GP DA Pilot Project' impact report is available by emailing ckimber@localsolutions.org.uk orkdowling@localsolutions.org.uk

20 domestic abuse champions across the trust and the senior domestic violence post they have in their A&E.

6.38 Within Mersey Care's IMR and in discussion with reviewers their senior managers recognised that had CMHT updated Holly's risk assessment in line with the Trust's policies, it should have been much clearer to treating clinicians within CMHT that she was exhibiting very high-risk factors for suicide and that addressing this risk would have benefitted from a multi-agency approach, not least because of the need to bring in expertise in stalking behaviours and ensure that all those support Holly understood her extended care plan and how the structured clinical management of her EUPD would likely be applied.

This would then have been available for the hospital based MHLT to inform their assessment when she attended the hospital following her first suicide attempt in early June 2022.

6.39 It should be noted that, prior to her attendance at A&E, Holly had assured CMHT she knew crisis numbers and would attend RLUH A&E if thoughts of self-harming became overwhelming. In discussions with reviewers, practitioners recognised (in hindsight) that for Holly the additional distress caused by the harassment coupled with the breakdown in her relationship could make it far harder for her to employ techniques and seek help before acting on negative impulses to self-harm.

For this reason, it was so important to have opportunities for the team around the person to come together and, if necessary, challenge professional optimism.

6.40 Domestic abuse practitioners confirmed, despite the very limited contact they had with Holly, they were able to complete risk assessments and safety plan discussions. This was undertaken by LDAS on the in May 2022 and graded silver. A further risk assessment later that month re-evaluated the risk as gold, triggering a notification to the police and a referral to MARAC and the IDVA service who completed a further assessment and discussed safety planning with Holly, who confirmed she had:

- Blocked the alleged perpetrator on all social media platforms.

- Confirmed how she kept herself safe in the community. She advised she went to choir practice twice a week and her friends made sure she got home safely.

- Holly declined refuge accommodation, or a house move and instead accepted a referral for the installation of telecare/panic buttons.

- She was reminded that there was a police 'treat all calls as urgent' (TAU) marker on her home.

- The IDVA also discussed civil remedies including application for Non-Molestation Order and court support should the Police matter advance to prosecution.

6.41 Reinforcing to her the importance of her piece of mind, specialist domestic abuse services also offered her an alternative phone. Holly explained she did not wish to change her mobile number believing that to do so would be "giving him the power". Her IDVA asked her to consider changing her number as "her peace of mind was more important".

6.42 The IDVA who had spoken with Holly was regretful that her death prevented more in-depth work but highlighted it had taken 4 weeks from Holly's disclosure to the police for her to meet with LDAS and a further 2 weeks for the level of risk to trigger a multi-agency response. Senior managers questioned whether the current domestic abuse risk matrix used by partners was sophisticated enough in complex cases. They highlighted that there are 40 questions/ issues to consider, only one of which references mental health. Within the VPRF, the risk of suicide is towards the end of the form so often not addressed.

6.43 They (and her brother) also questioned if responses to stalking and domestic abuse in general would be improved by adopting best practice applied to sexual abuse. Victims of sexual abuse receive support following first disclosure from a Sexual Abuse Referral Centre (SARC) so that all relevant agencies are in one place, thereby minimising re-traumatisation to the victim by ensuring contact is coordinated.

KLOE 4: What was known about Holly's presentations and previous intentional overdoses, was sufficient information shared across agencies involved in her care to evaluate the risk properly, given her heightened anxiety caused as a result of the harassment?

6.44 As identified above, whilst RLUH staff were able to ascertain Holly had overdosed and were aware of her diagnosis of EUPD, she did not disclose information regarding the ongoing harassment. This was, however, known by police conveying her to hospital, by her GP and by her CMHT support worker and responsible clinician.

That her reported trigger for the overdose wasn't shared with hospital staff was a critical missed opportunity. Given the context of malignant alienation (noted at 5.31), information about additional presenting risk factors is crucial to address common misperceptions that result in poor outcomes for patients with EUPD.

6.45 Practitioners from her GP practice highlighted Holly's long history of deliberate overdoses since 1999 and that she had access to high levels of medication so may have developed a high tolerance, such that she would not react in the same way another patient might to the overdose. They explained, following her attendance, they received notification from RLUH she had overdosed (which was good practice) and accepted over the Jubilee weekend the surgery would have been closed and so it would have been difficult for RLUH staff to make contact to ascertain directly if the GP had any concerns. However, RLUH staff confirmed they are able to access a patient's prescription history, independently from GP records. They accepted that her tolerance to medication would likely have been relatively high, given the high doses she was prescribed but (as set out in 3.23 above) took reasonable precautions to ensure her physical health was not likely to be at immediate risk before referring her for further assessment to Mersey care's MHLT.

6.46 It was to the MHLT clinician that Holly disclosed she was experiencing ongoing harassment that had motivated the overdose. It isn't clear if (or how) this information effected their risk analysis or why contact was not made (in line with policy and clinical guidelines) with the PD hub given the elevated risk factors present on the 02.06.22. It does not appear there had been a consensus sought between the MHLT clinical and RLUH colleagues on Holly's crisis management plan, but this was not required under the standard operating procedures at that time. Mersey care report the safety plan was agreed with Holly, but accept that this did not include her wider support network (e.g. by including her IDVA which should then have triggered a review of their MERIT risk assessment and safety plan). Her family, understandably, questioned why consideration wasn't given by MHLT to agreeing plans with CRHT and her supported living provider/ landlord to secure much more timely access to her home if CRHT was not able to make contact? Instead, the referral pathway appears to be designed as a handover rather than a joint decision between the teams and with the patient.

6.47 Crucially, CRHT did not seek to involve other professionals Holly was working within their crisis risk plan. The GP surgery staff confirmed they were not involved in any discussions regarding ongoing risk assessments with CRHT or notified directly she had died. Specialist domestic abuse practitioners were not contacted for advice, despite her reporting to have developed a rapport quickly with them. RLUH colleagues explained that, given the different issues involved in keeping Holly safe, this should be when practitioners call for an urgent multi-disciplinary meeting to understand what steps have been taken to alleviate pressures for her from the stalking/ harassment, whether the risk factors have changed (e.g. because of her relationship breakdown the previous day coupled with ongoing abuse) and if/how care could be safely delivered in the community including if she did not respond to CRHT contact.

6.48 Mersey Care accepted in their IMR and during discussions with reviewers 'the assessment following Holly's overdose revealed additional gaps in care, including the failure to conduct a comprehensive risk assessment using appropriate tools, make referrals to relevant agencies, engage with adult social care or her supported accommodation provider and communicate with the police.'

Their personality disorder policy re-iterates addressing these gaps is crucial to ensure proper intervention and safeguarding measures. These highlight the importance of improving risk assessment protocols, enhancing communication and collaboration among relevant agencies, and implementing trauma-informed approaches in cases of domestic abuse and stalking. The Trust have indicated their commitment to providing training and support to the mental health staff working in the Trust to increase their awareness of self-neglect, hoarding, and the impact of adverse childhood experiences on individuals with emotionally unstable personality disorder.

6.49 Holly was, as noted above, reluctant to discuss her family situation even with people she had developed trusted relationships with. However, the completion of a biosocial assessment is now a key feature within the Trust's policy to support patients with EUPD recovery. It is also critical in safety plans. They explained they have, since Holly's death, sought to improve practice and test adherence to policy through regular case audits.

6.50 Specialist domestic abuse practitioners explained they were already mindful that using police welfare checks too many times can have an adverse impact on the victim's wellbeing and that this needs to be carefully considered to prevent against re-traumatising. However, the purpose behind the extended care plan is to agree with the person what steps may need to be taken and by whom within their legal powers to ensure safety. As noted above, there is a proactive duty on statutory partners to protect life (Article 2, ECHR) whilst, where there is an imminent risk permits the police to use their powers of entry. Holly's case demonstrates insufficient understanding across police and partner agencies' frontline practitioners of what information is needed to be shared to trigger those duties.

6.51 In discussions practitioners and senior leaders noted the recent announcement by the Home Office of the intention to roll out a national 'Right person: Right care' approach but cautioned that within Liverpool this will likely negatively impact on safe care for adults with poor mental health if there isn't work done first to develop a better understanding of the duty of care and legal powers that underpin 'welfare checks.'

6.52 Holly's brother explained he had been advised that, prior to requesting a welfare check by the police Mersey Care staff have to have recorded three failed attempts at contact. If this is local policy or practice, urgent steps should be taken to reiterate the importance of professional judgement in respect of risk analysis. Panel members made clear that operational guidance still expect practitioners to use their professional judgement in respect of ongoing risks, and not to apply this as a blanket policy as this would be unlawful in public law and unsafe in practice.

6.53 The officers who attended Holly's home on the 05.06.22 were aware (because of LDAS and the IDVA's actions) of the TAU notification at her address. When CRHT made the request for a 'welfare check', the practitioners should have provided clear guidance as to why police powers of entry would likely be required. They should also have made clear the steps their service had already taken to make contact and explained the real and imminent risk given Holly's history and clear indication of the 02.06.22 that she intended to complete suicide. Ideally, the MLHT clinician, before agreeing discharge, should have updated the police as to the heightened risk so that, as soon as CRHT's contact attempts failed, more assertive attempts either using the landlord's or police powers of entry would be justifiable. This would be a 'whole system approach'. This would not be a breach of confidentiality or prohibited by data protection legislation, as an exception will always apply when there is an immediate threat to life.

6.54 Again, Mersey Care's IMR reported 'since this incident, ongoing transformation work has taken place within both Community and Urgent Care Service Lines of Mental Health Care Division which includes increased work on 'Safety Planning'.

Since January 2023 'Safety Flashcards' are utilised within Urgent Care Services, which are person-centred and support the patient to identify strategies for coping during times of crisis. The flashcards are co-produced during assessment between the practitioner and patient. The service completes regular audits of the flashcards to ensure best practice and compliance. The results of these are shared with Senior Leadership for the service line. Furthermore, the Community Service Line of the division is continuing to implement safety plans across the division which is also audited.[69]'

[69] Taken from Mersey Care Trust's IMR prepared for this review.

KLOE 5: How well does risk evaluation between Careline, the police MASH and MARAC processes work where the adult at risk is known to have enduring mental health conditions?

6.55 As noted above, it took 6 weeks from Holly's disclosure to the police for assessments to identify the level of severity and/or type of abuse warranted a multi-agency response. Thereafter it was scheduled to be heard on 23.06.22, a full 10 weeks after the disclosure, by which time Holly had passed away.

Whilst all those involved in this review recognised current arrangements for MARAC to review newly referred urgent cases at the next available fortnightly meeting caused some delay in agreeing a shared plan, they were keen to highlight this did not prevent agencies from working with victims (or across disciplines) to agree safety plans. The IDVA service's IMR commented that MARAC allowed for additional information gathering and to jointly plan and identify appropriate interventions. In advance of MARAC, IDVA would have offered to meet with Holly face to face and would have begun the process of linking in with the agencies who had knowledge of Holly and her needs. IDVA and LDAS confirmed that usually by each MARAC meeting much of the facts are known, so victim survivors have holistic plans, the actual MARAC forum tends to rubber stamp the safety plan already agreed but can, if necessary, unblock any barriers to effective multi-agency practice.

6.56 LCC's adult social care explained how having a dedicated social worker now attending MARAC had greatly improved cross agency working as it had enabled their service to build relationships with IDVAs working across Liverpool.

Many were keen to explore how local systems could harness technology to ensure information about risk and need could be shared safely at the earliest opportunity rather than wait for formal meetings to facilitate faster agreement for interim safety plans.

6.57 In Holly's case police, careline staff, domestic abuse experts all completed their own processes in line with local policy ensure that appropriate referrals were made so that she could benefit from dedicated support. It is also important to highlight staff within CMHT demonstrated application of their suicide prevention training as duty workers and GP staff asked relevant questions and sought assurance from Holly that she would seek help if overwhelmed, However, as set out above, these processes are linear; they require each contact to make further referrals rather than bring together expertise across different disciplines to ensure that the support Holly received was holistic and took into account her needs in a person centred, trauma-informed way. Agencies involved knew of Holly's intersecting needs as a result of her physical and mental ill health and that she had trauma, including suffered sexual harm. Partners involved in this review should reflect on how to enable systemwide expectations for reasonable adjustments to ensure access to services to protect victims of stalking. The current linear risk identification and management process resulted, for Holly, in delay and an overreliance by the police on her ability to report further crimes before they progressed the investigation and, for other agencies, on the police to prevent the ongoing abuse. In short, each agency worked in silo.

6.58 Adult safeguarding processes are designed to empower any agency to bring together a 'team around the person' to better understand the type of abuse, level of risk and the ability of the adult to keep themselves safe.

This process (in common with MARAC) can also decide what action is needed to hold perpetrators to account. These powers were not triggered when the VPRF1 was triaged by Careline, but equally no other agency working with Holly considered this option. That includes when hoarding was identified as a high risk to her wellbeing or in response to the additional pressure caused by the stalking. As noted above, Holly's EUPD and co-occurring conditions made it harder for her to maintain her wellbeing and stay safe. Holly was open with practitioners about the additional distress caused by the stalking and that this increased the risk that suicidal ideation (a feature of her illness for many years) would move into active plans. She disclosed to WHISC staff on 02.06.22 that she felt like no-one was listening to her, that she felt alone and hopeless. Whilst

WHISC staff provided reassurance that they were there and would listen, they rightly prioritised her accessing treatment for the overdose. She was also explicit on 02.06.22 with the MHLT clinician that she did not believe she could use techniques previously employed to overcome those negative feelings.

6.59 MHLT clinicians could have triggered, either as part of the discharge plan or separately under s42 Care Act 2014, a multi-agency discussion requesting confirmation from the police about the steps they had taken to prevent further abuse.

They could have made contact with her IDVA and LDAS to understand their support offer and, with Holly, then assess if this support and action by the police would alleviate her feelings of hopelessness. As set out above, it was crucial that Holly and professionals involved in her care understood the rationale for not admitting her on 02.06.22 and knew how they could reinforce to Holly that she would be supported to recover from the abuse and manage the symptoms of her EUPD.

6.60 Mersey Care's IMR identified missed opportunities in her care. The failure to explore underlying difficulties, recognise signs of domestic abuse, and address escalating risks indicates the need for improved response and intervention in cases of domestic abuse and stalking from Trust staff. Professional curiosity plays a vital role in addressing these identified gaps.

It could have prompted mental health practitioners to delve deeper into her difficulties, feelings of isolation, emotional dysregulation, and concerns about her relationship. By investigating these issues further, professionals may have identified signs of domestic abuse or stalking, triggering appropriate safeguarding actions and multi-agency shared safety planning. Furthermore, professional curiosity could have prompted professionals to explore the reasons behind her fears of leaving the house and her belief that she would be assaulted. It may also have revealed the escalating financial adversity described by her brother which is another key risk factor for suicide or enabled proper exploration of whether she had been a victim of financial abuse and, if so, prompted action to redress this. This curiosity could have led to a more

comprehensive assessment of her safety and a deeper exploration of her concerns related to potential harm or ongoing abuse.

6.61 LCC's adult social care department report that since this time, there have been significant developments in safeguarding adults across Adult Social Care and Health which include updating the VPRF screening process to enhance screening and information gathering and initial enquiries regarding safeguarding concerns. Furthermore, since November 2022 all safeguarding concerns are screened by the social work team at Careline with an expectation that they make further enquiries to determine decision making. Team managers have been allocated greater responsibilities for reviewing and quality assuring the work of the team which enables feedback in real time regarding team and individual performance.

6.62 The learning in Holly's case presents a strong case for trialling physical dedicated domestic abuse resource hubs and co-locating IDVA services strategically with certain frontline services (e.g., primary health care hubs, emergency departments, mental health liaison, children, and adult social care etc) as this has demonstrably improved identification of risk, take up with early intervention support and follow up with therapeutic support.

6.63 Likewise increasing capacity within the system for stakeholders to identify those in need of therapeutic support will reduce 'handovers' between agencies, thereby preventing the need for victims to retell their story as well as reduce the time spent by specialist safeguarding staff and domestic abuse leads gathering information and completing further risk assessments.

Consideration should be given by the Partnership to undertake a feasibility study to ascertain how police to share information with universal health services (e.g., the child or adult at risk's named GP, District nursing, Health Visiting/School Nursing and Maternity as appropriate). This will complement the practice of shared risk and care management between Police and mental health services through the Liaison and Diversion Service and Street Car

Triage and LSCP's plans to extend Operation Encompass notifications to social landlord in areas of the city with relatively high levels of care entrants.

KLOE 6: Were CPS involved in a timely manner, according to expected standards and notified of the impact of the abuse on Holly? Is there evidence that the CPS took the circumstances of her death into account when determining this as a summary offence?

6.64 CPS guidance[70] explains that when police request a charging decision they must provide '*required material and information on first submission to enable prosecutors to take decisions promptly… [and] must set out the rationale for the assessment that both the evidential and public interest stages of the Full Code Test are met or each of the 5 conditions of the Threshold test are met'*.

The Full Code Test is made up of two parts, firstly an evidential test. This is met if there is sufficient evidence to provide a realistic prospect of conviction. This should consider if evidence is admissible, credible and reliable. If this is met, then consideration must be given to the second part, namely any factors that suggest it is not in the public interest to prosecute. The threshold test applies to a limited range of cases where the Full Code Test cannot be met, but the overall seriousness or circumstances of the case justify the making of an immediate charging decision, and there are substantial grounds to object to bail.

6.65 In addition to requesting the CPS make charging decisions, police can seek early advice for serious, sensitive or complex cases, there is no expectation that early advice is sought for every case involving domestic abuse, stalking or harassment.[71]

The guidance states 'investigators must consider seeking early advice in serious, sensitive, or complex cases. Cases involving a death, rape, or other serious sexual offence should always be considered for early referral,

[70] 'Charging (The Director Guidance) 6th edition, published Dec.'20, section4.16-17 (available at https://www.cps.gov.uk/legal-guidance/charging-directors-guidance-sixth-edition-december-2020-incorporating-national-file)

[71] This is governed by the Director's Guidance on Charging (6th Edition). The purpose is to provide advice on specific issues that arise in the course of the police investigation into serious, sensitive or complex cases which may allow aspects of the investigation to be more focused. Holly's case may not have fallen into the category of case expected or likely to be referred to the CPS for early advice.

particularly once a suspect has been identified and it appears that continuing the investigation will provide evidence upon which a charging decision may be made… The timing of the request for early advice is a matter for the investigating officer. It should usually follow a police supervisory review at the point of the investigation where the key evidence is understood, even if not fully developed, and the issues in the case have been identified.'[72]

6.66 In discussion with the reviewer, CPS senior staff advised that the first contact they had for a charging decision was on the 25.10.22. Their service level agreement requires they provide pre-charge advice within 28 days and the CPS lawyer met this requirement.

It is understood that CPS staff do not have independent access to police records and are dependent on the police to gather and submit all relevant evidence in a timely manner.

6.67 Holly's handwritten log, retrieved by her brother after her death was submitted to the CPS on the 25.10.22. The handwritten log was considered by the reviewing lawyer as inadmissible within any subsequent criminal trial as it could not be attributed to Holly.

Unfortunately, the calls that weren't answered from the perpetrator's number didn't match the dates on the handwritten log. Holly had previously advised that the perpetrator used withheld numbers and that she believed he also asked his friends to call her, so the numbers may not all have matched the perpetrator's number stored on Holly's phone. As Holly could not, by then, substantiate within a witness statement what she was recording within the handwritten log, this meant that the CPS could only use the dates given within Holly's first statement taken by the initial officer (on the 20.04.22) which detailed the contacts made between March and April 2022 (as well as the subsequent contact shown in the phone records) as evidence of a course of conduct. Without additional explanation from her in the form of a witness statement, they were not satisfied of sufficient objective evidence (such to withstand the

[72] Section 7.3 and 7.5 of the CPS charging guidance.

evidential test) that the course of conduct subsisted between April and June 2022.

6.68 In addition, whilst the investigating officer did explain within their submission that Holly had died by suicide, the failure to take further statements detailing the adverse impact the calls had on Holly, together with her previous assertion on the 20.04.22 that she did not fear violence, caused the CPS lawyer to form the view the summary offence (under s2 PfHA) was the correct offence and, because of the strict time limits which apply to that offence the police was out of time to charge the perpetrator by the time the request for a charging decision was submitted on the 25.10.22.

6.69 Had earlier advice been sought by the investigating officer, the CPS can provide clear guidance to officers on what evidence to gather to enable a higher charge. Equally, had Holly been asked to give a further statement setting out the impact of the behaviour on her day-to-day activities and her wellbeing, the CPS could have considered the further statement as part of the evidential assessment.[73] There is evidence of a misunderstanding between the officer in charge and the reviewing lawyer in relation to the alleged period of the course of conduct as demonstrated in the evidence submitted. A telephone discussion may have brought greater clarity and understanding given the very short window to charge the perpetrator if the call on the 03.06.22 could be evidenced as part of a course of conduct.

[73] Any evidence provided by Holly would have been subject to the rules governing hearsay evidence if proceedings have commenced after Holly's death

6.70 Again, as noted above, if the investigating officer had worked with Holly and professionals involved in supporting her, this could have provided a stronger factual matrix that the nature and frequency of the contact was causing Holly distress that had a substantial adverse effect on her day-to-day activities. Equally, this may have encouraged comprehensive evidence to be submitted to the CPS in a timely way, so that even if it were on the lower charge, the perpetrator would be held to account and Holly would have had access to justice.

6.71 There was a perception among other professionals that too often police and CPS colleagues only prosecute the cases they can win. As explained above, the law requires they must be satisfied of a 'realistic' prospect of conviction. However, all accepted more needs to be done to challenge misperceptions that victims experiencing stalking and harassment with additional complex needs are not subject to unconscious bias.

Staff from MDVS explained that, because generally the pervasive and insidious nature of stalking, it can have a profound impact on victims which may then mean they report concerns which cannot be verified. They argued generally this should not be assumed by police or CPS colleagues to undermining their credibility as a witness, but rather demonstrate the impact that such behaviours have on the day-to-day activities of victims. This accords with national reports into responses to all forms of criminal violence against women and girls and reinforces the importance of the Victim's code to ensure the onus is not on the victim to prove a case, particularly if this can be verified through other means of collecting evidence, including assertive conditions applied via SPOs.

6.72 In addition to the national stalking protocol, CPS and Merseyside police have systems in place to provide managerial and strategic oversight of operational practice. Whilst all CPS reviewing officers receive training to undertake their duties, they are also line managed by legal managers. The CPS management system cannot currently flag cases coming close to time limits, but any referred for advice close to those time limits will be bought to the attention of the allocated lawyer. The HMCPSI inspection into domestic abuse cases recommended that by March 2024 the CPS introduce a system for domestic abuse cases that identifies any summary time limit applicable on receipt from the police at pre-charge and ensures that the case is progressed effectively and efficiently within the summary time limit. It was reported to this review that processes are currently being created to action that recommendation within the time limit.

6.73 The CPS has a process of Individual quality assessments through which line-managers monitor the timeliness and quality of every lawyer's work and decision-making. If a police officer receives a pre-charge decision they wish to question, police can appeal which requires a manager to review the case. There is also a Victim Right to Review process which is available if the CPS/police so not lay any charge or end proceedings.

6.74 Locally the police and CPS are working to improve access to justice for victims of domestic abuse, via the 'JOIM' joint operational improvement meetings that meets monthly. They reported all staff have received domestic abuse training and are working to embed champions across teams. The CPS also has a specific stalking and harassment lead who meets with police leads to discuss charging/ disclosure issues to improve a whole system response. Despite this work, they wanted this review to highlight that improvements in prosecutions require a better understanding across partner agencies of the legal requirements (charging guidance, rules of admissibility) so that all agencies are working together and with the victim to build a case that can be prosecuted at the earliest opportunity.

7 Conclusions

Police Response to Stalking/Harassment Disclosure

7.1 The police investigation did not follow the national protocol, Victim's code or standard investigative practice resulting in missed opportunities to prevent Holly experiencing further abuse. Too little consideration was given to the adverse impact that the abuse had on Holly's fragile mental health.

7.2 Insufficient action was taken to secure evidence (phone records, interview the perpetrator) in a timely way. Delays in completing paperwork correctly and interviewing the perpetrator remain unexplained. Supervising officers did pick up on delays and provide guidance to the investigating officer, but this did not result in closer monitoring to prevent further drift. There was no consideration given to the use of preventative police powers and when the use of those powers could be triggered. Instead, the investigative approach relied very heavily on the victim's ability to report further contacts before any active steps were taken by the police.

7.3 Critically, there was no discussion with Holly or her professional support network to better understand the adverse impact continued abuse would have on her mental health or how this might elevate suicidal ideation. Opportunities to complete risk assessments were not taken by the investigating officer, nor were attempts made to agree a shared risk management plan with relevant partners to enable trauma-informed practice and secure best evidence. Recommendations 1 and 2 relate to this key line of enquiry.

Understanding Different Offences Applicable to Stalking Behaviours

7.4 Presently, there is not a widespread, shared understanding of the evidential burden police and CPS require to progress criminal proceedings in respect of stalking and harassment across partner agencies. This is limited to specialist domestic abuse provider services. Increasing opportunities to share pertinent information between police, domestic abuse practitioners, the victim and practitioners providing their health and social care support will enhance the police' ability to implement the Victim Code for victims experiencing harassment, stalking or coercive and controlling behaviours. Recommendations 3 and 4 relate to this key line of enquiry.

Multi-Agency Understanding of Risk

7.5 Opportunities to understand the impact of the harassment on Holly and her ability to stay safe were not assessed at the earliest opportunity. Poor compliance with risk review and management within the CMHT equally prevented a holistic understanding across professionals involved in her care. Recommendations 5 and 6 relate to this key line of enquiry.

Multi-Agency Information Sharing

7.6 Risk management for those at heightened risk of suicide is not cohesive across partner agencies. Information is not shared in a meaningful way to enable frontline staff to respond, even when they have legal powers to do so, with the urgency required. Preventative, pro-active steps to reduce reliance on police powers of entry were not evident, despite numerous high-risk factors present indicating that swift and regular face to face contact would be needed to reduce the risk of serious self-harm or suicide. Recommendations 7,8 and 9 relate to this key line of enquiry.

The Interface between MARAC and Adult Safeguarding Processes

7.7 Currently the MARAC and adult safeguarding processes are employed as separate, distinct processes. Both require a 'recognise and report' model of practice and the referral pathway is linear potentially increasing delay and duplication. It also makes it more likely that domestic abuse cases not deemed 'high risk' under the gold referral pathway do not benefit from early planning or de-escalating interventions, despite this being the purpose of the safeguarding adult's legal duty under s42 Care Act 2014 and a key aim of the Domestic Abuse Partnership Board's strategic plan. Recommendations 10 and 11 relate to this key line of enquiry.

The Role of the CPS in Charging Decisions

7.8 The CPS were not involved in decision making in a timely way. Consideration wasn't given by the Investigating Officer to the Charging guidance, nor did they seek early advice. Whilst it is unlikely that the nature of the abuse Holly suffered would fall within the type of matters that required early advice to be sought, the delay in submitting information by police in breach of expected standards and in securing evidence from Holly regarding the impact for her of the ongoing abuse prevented criminal justice agencies from holding the perpetrator to account. Recommendations 12 relate to this key line of enquiry.

8 Lessons to be learnt

8.1 A key learning point for anyone reading this report is that victims should not be advised to block perpetrators from their number, but instead offered a secondary phone to daily use with professionals and friends. This is to ensure it is easier to provide evidence of continued attempts to harass. Victims should be advised to leave the old phone charged and on silent and to forward screen shots directly to the police.

8.2 Public health experts also explained the need for better guidance to triage and first responders of the risk factors common to suicide and for A&E staff to feel confident to openly discuss with someone why/ when suicidal ideation may move over into active plans. This cannot be solely the responsibility of secondary mental health teams if Liverpool wishes to be 'safe from suicide'.[74]

9 Recommendations Emerging from This Review

9.1 The police (working with the Police and Crime Commissioner) provide assurance to CitySafe and the Domestic Abuse Partnership Board that training on stalking prevention orders and the national stalking and harassment protocol has been provided to all frontline officers. They should also report on take-up by police staff of Mersey Care and LCC's suicide prevention training offer.

9.2 The police and PCC to agree data it will provide to the partnerships, on:

timeliness of stalking and harassment investigations.

involvement of professional support networks where victims have EUPD to ensure a trauma-informed approach.

referrals by the police under VRPF1 or MARAM called by police staff for vulnerable victims/ perpetrators for stalking/ harassment.

[74] An aspiration endorsed by the Mayor and advocated by the Zero Suicide Alliance: https://www.zerosuicidealliance.com/stories/ambassadors/steve-rotheram-liverpool-metro-mayor

9.3 The Partnership, working with domestic abuse providers, police and PCC, provide a practitioner's briefing (taking into account the published CPS guidance) with descriptors so that victims and perpetrators (as well as practitioners) know how to distinguish between the different offences, what information to share to evidence legal thresholds for each type of offence and how these interface with civil powers so that victims and practitioners are empowered to prevent ongoing harm and perpetrators can more quickly be held to account. This should also highlight existing processes for multi-agency risk management (including s42 Care Act duties and MARAM) and referral pathways for existing services in Liverpool (including those offered by MDVS) to support victims of stalking and the 'make a change' intervention programme for perpetrators**.**

9.4 The Partnership write to local courts liaison groups and the Chief Constable to seek assurance that recommendations from the joint Courts and Home Office review have been implemented. Particular regard should be had to the requirement that '*forces consult with the victim or a stalking advocate when drafting conditions to ensure they are tailored to the victim's case.*'[75]

9.5 The Partnership (working with the Domestic Abuse Partnership Board) to explore options for a single point of access for people experiencing domestic abuse, include stalking/ harassment similar to SARC but for those experiencing domestic abuse, including stalking.

9.6 ICB provide assurance that they will actively supporting the development of domestic abuse champions across primary care and secondary mental health trusts, with a specific focus on upskilling frontline practitioners to complete DASH/SASH risk assessments and, with reference to this case, that the onus is on practitioners to come together for a shared risk management plan so the

[75] Ibid, Recommendations (section 7).

burden is not on the victim to coordinate their care and progress the police investigation.

9.7 RLUH and Mersey Care should provide assurance to the Partnership that their discharge pathway from A&E and MHLT has been reviewed to strengthen transfers of care and support cohesive and collaborative safety and care planning between the patient and services on each side of the transfer.

9.8 Mersey Care Trust provide assurance that staff within CMHT, CRHT and MLHT have completed suicide prevention training in line with the Trust's suicide prevention policy. That relevant assessment and, particularly the extended care plan for those with EUPD, have been updated to include specific questions regarding suicide risk factors, domestic abuse (stalking and harassment) and emergency contact are included within safety plans. The Trust should consider, as part of their action plan for this review, timetabling within 2023/24 workplan an audit of case files from CMHT, CRHT and MLHL to explore if safety plans comply with their Personality Disorder and safeguarding policies as well as good practice expectations.

9.9 Partner agencies working with Merseyside Police should produce a briefing on powers of entry and the information required to trigger those powers if a person's welfare requires checking. In preparation for the role out of 'Right Person; Right Care' all partners agencies should highlight their own organisational duty of care to conduct welfare checks of service users who might be a risk, rather than relying on police to carry these out in all situations.

9.10 The Partnership may find it beneficial to review guidance on the MARAC referral pathway to remind practitioners they are lawfully entitled (and may have a duty of care) to utilise powers under s42 Care Act to bring together practitioners with the adult at risk to formulate shared understanding of needs, risks and agree interim safety plans.

9.11 Review stalking/harassment risk assessment so there is more weight given to psychological impact, particularly for those who have existing mental health conditions which, research confirms, escalates the risk of suicide.

9.12 Merseyside Police should provide an assurance report to the Partnership in respect of the timeliness of referrals to the CPS in respect of stalking and harassment cases and, if this identifies systemic issues in respect of delay, devise an action plan to remedy this.