Stafford Community Wellbeing Partnership

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

in respect of

B

February 2017

Chris Few

December 2020

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INTRODUCTION

1 SUMMARY OF CIRCUMSTANCES LEADING TO THE REVIEW

1.1 The victim (B) and perpetrator (K) had been in a relationship for around 10 months when, in September 2016 she ended the relationship. She was thereafter subjected by K to a campaign of Harassment, Stalking and intimidation. In connection with this B had contact with agencies in Staffordshire and Cleveland.

1.2 In February 2017 the body of B was found hanging at her home. She had left notes suggesting attribution of her death to the actions of K.

1.3 K was subsequently arrested and charged with Manslaughter, Engaging in Controlling Coercive behaviour and Stalking involving serious alarm/distress with regard to B. K was also charged with Stalking involving serious alarm/distress in relation to five other victims.

1.4 On 25 April 2017 a Scoping Panel convened on behalf of the Stafford Borough Community Wellbeing Partnership considered the circumstances of the case and concluded that the criteria for conducting a Domestic Homicide Review were met. A recommendation to commission a Domestic Homicide Review was endorsed by Tracy Redpath, Chair of the Community Wellbeing Partnership, who was present at the meeting.

1.5 In June 2017 K pleaded guilty to all charges and in July 2017 he was sentenced to 10 years imprisonment with a 15-year licence requirement for the Manslaughter of B and additional concurrent sentences of 4 years imprisonment for each of the other offences. He was also made the subject of a lifetime Criminal Behaviour Order.

1.6 HM Coroner for Staffordshire opened and adjourned an inquest pending the outcome of the criminal trial. That inquest will not now be reconvened.

2 REVIEW PROCESS

2.1 The Review considered in detail the period from September 2016, when the relationship of the B and K first came to the attention of agencies, until the date of the B's death; extended to 1 March 2017 (when K was discharged from Harplands Hospital) for North Staffordshire Combined Healthcare NHS Trust. The review also considered summary information regarding B and K outside of this period including retrospective accounts of the relationship provided by the family and friends of B.

2.2 In conjunction with the areas for consideration outlined at Section 4 of the Statutory Guidance on Domestic Homicide Reviews, the Review specifically considered Coercive and Controlling Behaviour directed at B, its impact upon her and the response of services to this.

2.3 The Review Panel was chaired, and the Review was written by Chris Few, an Independent Consultant. Mr Few has had a career in law enforcement and undertaken responsibility in senior leadership roles. He has completed the Home Office online DHR learning provision in 2013, attended a Home Office sponsored AAFDA/STADV facilitated training workshop for DHR chairs in 2017. Since 2008 he has worked as an Independent Consultant in Somerset, Bristol, Gloucestershire, Oxfordshire, Bedfordshire, Northamptonshire, Nottinghamshire, Nottingham City, Derbyshire, South Yorkshire, Stoke on Trent and Staffordshire.
Since that time, he has chaired Review Panels and written overview reports on behalf of numerous Community Safety Partnerships, Local Safeguarding Children Boards and Local Authorities in connection with Domestic Homicide and Serious Case Reviews as outlined. He has no current or historic personal or professional connection with any of the agencies and professionals involved in the events considered by this Review.

2.4 The Review Panel comprised the following agency representatives:

- Jem Milson; Detective Inspector — Cleveland Police
- Mathew Hollingsworth; Detective Inspector — Cleveland Police
- Service Manager — Refuge provider
- John Mason; Deputy Head of Service — Stoke and Staffordshire National Probation Service
- Liz McCourt; Quality Manager — NHS England (North Midlands)
- Victoria Baxendale; Safeguarding Lead — North Staffordshire Combined Healthcare NHS Trust
- Amy Davidson; Safeguarding Lead — North Staffordshire Combined Healthcare NHS Trust
- Sarah Hankey; Quality and Risk Officer — Midlands Partnership NHS Foundation Trust (formerly South Staffordshire and Shropshire Healthcare NHS Foundation Trust)
- Tracy Redpath; Corporate Business and Partnerships Manager — Stafford Borough Council (Chair of the Stafford Community Wellbeing Partnership)
- Victoria Cooper; Community Safety Lead — Stafford Borough Council
- Lisa Bates; Lead Nurse - Adult Safeguarding — Staffordshire CCGs (in respect of primary care services)
- Julie Long; Principal Community Safety Officer — Staffordshire County Council
- John Maddox; DHR Coordinator & MASH Principal Officer — Staffordshire County Council
- Simon Brownsword; Head of Safeguarding — Staffordshire Police,
- Victoria Downing; Senior Investigating Officer — Staffordshire Police,
- Paul Cooke; Deputy Head of Safeguarding — Staffordshire Police
- Mark Harrison; Review Team – Specialist Investigations — Staffordshire Police
- Joanne Moss; Coordinator — Staffordshire Victims Gateway
- Dickie James; Chief Executive — Staffordshire Women's Aid
- Janice Johnson; Senior Nurse – Safeguarding — University Hospitals of North Midlands NHS Trust
- Carly Manning; Head of Safeguarding — West Midlands Ambulance Service NHS Foundation Trust
- Nicola Albutt; Head of Safeguarding — West Midlands Ambulance Service NHS Foundation Trust.

2.5 Individual Management Reviews and Summary Information Reports were submitted by:

- Cleveland Police
- Refuge provider
- National Probation Service
- North Staffordshire Combined Healthcare NHS Trust
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust (now Midlands Partnership NHS Foundation Trust)
- Stafford Borough Council
- Staffordshire and surrounds CCG (in respect of primary care services)

- Staffordshire County Council
- Staffordshire Police
- Staffordshire Victims Gateway
- Staffordshire Women's Aid
- University Hospitals of North Midlands NHS Trust
- West Midlands Ambulance Service NHS Trust.

2.6 Other sources of information accessed to inform the Review included:

- Record of events prepared contemporaneously by B's husband
- The report of an Independent Office for Police Conduct investigation into referral by Staffordshire Police of B's death and formal complaints from B's family and friends; along with an associated report of the IOPC Decision Maker
- Responses to a formal complaint lodged by a friend of B with University Hospitals of North Staffordshire NHS Trust about responses provided to B by that organisation, South Staffordshire and Shropshire Healthcare NHS Foundation Trust and West Midlands Ambulance Service NHS Trust, which also informed the reports of those agencies to the Review Panel
- Copy email dated 15 February 2017 from B's husband to Staffordshire Police.

2.7 In addition to the Scoping Panel Meeting in April 2017 the Review Panel met on three occasions in July 2017, October 2017 and June 2019 to consider contributions to and emerging findings of the Review. The final draft of the Review report was endorsed by the Review Panel on 19 December 2019. and forwarded to the Chair of the Stafford Community Wellbeing Partnership. On 10 July 2020 the report was endorsed by the Stafford Community Wellbeing Partnership.

2.8 Completion of the Review was significantly impacted by delay in completion of the IOPC investigation, the report of which was provided to the Review Panel Chair in April 2019, and subsequent agreement of agency contributions to the Review. Endorsement of the final report by the Community Wellbeing Partnership was further delayed as a consequence of the Covid19 pandemic.

3 FAMILY ENGAGEMENT

3.1 All family members and friends of B were advised that the Review was taking place at its outset[1]. Meetings with individuals who wished to contribute to the Review were postponed at the request of the Police to prevent compromise of the criminal prosecution and then the IOPC investigation. In January 2018 the Review Panel chair was advised that the IOPC no longer had any objection to him meeting with family members and friends of B.

3.2 On 17 January 2018 the Review Panel Chair met with B's husband and sister and explained the review process and focus, including its relationship with the parallel processes. On 18 January 2018 he similarly met with two friends of B, referred to in this report as F1 and F2. Information provided by and the views of these family members and friends are included within the body of this report. The Review Panel is very grateful for their contribution to the Review.

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[1] Establishment of contact with family members was through the Police Family Liaison Officer who hand delivered and explained letters from the Review Panel Chair, which included details of available support and advocacy services.

3.3 Family members were asked if they would wish a pseudonym to be used for B in this report. They collectively stated that they did not and initials, having no relationship to those of individuals, have therefore been used to anonymise the report.

3.4 K was advised of the review at its outset. No response was received to correspondence from the Review Panel Chair.

3.5 Members of B's family and her friends were given sight of this report on completion and prior to its submission to the Home Office.

BACKGROUND

3.6 The Victim, B, was aged 46 years at the time of her death. She was married and had one adult child from an earlier relationship. The father of B's child did not feature in his life.

3.7 In 2014 B was raped by two men at a Scooter Club rally. This was not reported to the Police at the time and B did not make her husband aware of what had happened. It was however described by a friend of B, who was aware of it, as having had a serious impact on her life and marriage.

3.8 B had known the perpetrator, K, in the 1980s. She met K again about 15 months before she died and subsequently left her husband to live with him. Notwithstanding their separation B remained on good terms with her husband and they have been described as best friends.

3.9 K was 46 years of age at the time of B's death.

3.10 K was known to criminal justice agencies as a high-risk domestic violence perpetrator in connection with Harassment, Stalking, Battery, Threats to Kill, Assault Occasioning Actual Bodily Harm, Common Assault, and Criminal Damage offences against previous partners.

3.11 A friend of B advised the Review that B described K as initially making her feel safe and think she could be happy with him.

3.12 About two weeks after moving in with K, B is however reported to have told her friend that she was living with a Psychopath. B moved in with her friend for about two weeks during which time she was bombarded by K with phone calls and text messages which eventually persuaded her to return to live with him. This pattern was repeated over the following months during which B told her friend not to let her go back to K, although attempts to persuade B not to do so were unsuccessful. On one occasion B is reported to have travelled to Brighton to get away from K, only for him to trace and follow her there, persuading her to return.

3.13 B's friend informed the Review that to her knowledge K never beat B, but he had threatened her and her dog, thrown things at her and physically prevented her from leaving the house. He is also reported to have made B get out of his car and abandoned her on the hard shoulder of a motorway.

3.14 K is reported to have told B that he had been in the army and that he knew people who would kidnap the men who had raped her if B named them. It is not known if K did know such people but the thought of this is understood to have subsequently made B fearful about what might happen to her and her family.

REVIEW FINDINGS

3.15 During the period under review B had involvement with domestic abuse support services and Police in Staffordshire and in Cleveland, where she accessed refuge services for 4 weeks in October/November 2016; as well as health services, mainly in relation to her mental health and an attempt to end her life in February 2017. The overview report of this Review contains a fuller account of events than would normally be the case owing to the nature of the abuse to which B was subjected; being an ongoing course of conduct that impacted upon the mental and physical wellbeing of B rather than one or more discrete index events.

3.16 Notwithstanding the detail examined by the Review, agencies' contemporaneous records of involvement with B give only a limited insight into the level of continual Stalking and threat that she was subjected to by K. For example, in the six months prior to her death the Police recorded 14 incidents following reports from B about K's behaviour; but during the same period she had around 3500[2] phone calls, texts and social media messages sent to her from K. It is unsurprising that this level of abuse created for B a world of constant fear and anxiety.

3.17 The Review considered the effectiveness of services engaged with B, individually and as part of a multi-agency framework. The main findings of the Review are outlined below.

4 SUPPORT AND REFUGE SERVICES

4.1 B had extensive contact with Women's Aid during the period under review. Provision of support was mainly by telephone as opposed to a face to face service sought by B. This was not compliant with the service commissioned from Women's Aid.

4.2 There was a lack of clarity for professionals and service users regarding the benefits and limitations of counselling services provided by Women's Aid for victims of Domestic Violence and Stalking.

4.3 B found a lack of clarity regarding the role of victim support provision and coordination of this with more specialist support services.

4.4 The funding arrangements for refuge services, including the classification of refuges as supported housing, undermines their accessibility to service users who are not in receipt of state benefits.

4.5 Since 1 October 2018, a new holistic domestic abuse service has been operating across Staffordshire and Stoke-on-Trent, jointly commissioned by the Staffordshire Police Commissioner's Office, Staffordshire County Council and Stoke-on-Trent City Council. Services for victims are provided by Victim Support and support for perpetrators is provided by the Reducing Re-offending Partnership; both operate under the name of "New Era".

4.6 The New Era service specification for supporting victims continues to state that the nature and level of support provided will be led by risk and needs assessment, and may vary over time, but that periodic support visits will be made to service users at their home or at other venues chosen by the service user. The service specification is considerably more specific about the nature of the services to be provided and expected outcomes than previously.

4.7 During the period under review there were no local services in Staffordshire for victims of Stalking behaviour, such as that to which B was subjected. There were and continue to be, Independent Stalking Advocacy Caseworker (ISAC) services provided nationally by Paladin and the Suzy Lamplugh Trust. These were not however engaged by, or on behalf of, B. The

[2] The exact number has not been established as some social media messages were deleted intentionally by K or automatically by the social media platform. Analysis of this by the Police was discontinued following K's guilty plea.

Review panel concluded that this was attributable to a lack of awareness regarding Stalking and the specialist services available.

5 POLICE

5.1 There was inconsistency in the categorisation, cross referencing and background research of the 34 incidents recorded by Staffordshire Police during the period under review. This contributed to incidents being dealt with in isolation and a lack of recognition that they represented a course of conduct by K which should have been identified as Stalking. Such recognition may in turn have led to greater coherence in the responses given to both the incidents themselves and investigation of the crimes reported.

5.2 The Review Panel noted that the risk assessments conducted (using the DIAL risk assessment tool) only related to a specific point in time and there were inconsistencies in B's responses to successive assessments. In this regard the Review Panel concluded that over the numerous contacts which B had with Police Officers and other professionals there would inevitably have been changes in the focus of accounts given by B, reflecting both the nature of the index event but also conscious or unconscious assumptions that professionals would already be aware of previously imparted information.

5.3 Overall co-ordination between services in Cleveland and those in Staffordshire was generally effective. There was direct conversation between the two Police forces and good communication between Staffordshire Women's Aid and the Refuge.

5.4 A total of 21 crimes were recorded by Staffordshire Police in respect of the events described in this report. Of these 9 were for malicious communication and 7 were for breach of the Non-molestation Order. It could be argued that recording offences of Stalking in respect of these crimes, as an alternative to or in addition to these categories, as well as for two incidents recorded as non-crime domestic incidents, would have promoted consideration of K's actions as a course of conduct requiring a holistic coordinated response and a greater emphasis on effective cross referencing. The Home Office National Crime Recording Standard (NCRS) was amended in July 2018 to make Harassment and Stalking offences an exception to the principle crime rule (that where more than one crime type is involved the most serious should be recorded). This introduced an expectation that Stalking or Harassment should be recorded in addition to any other notifiable offences, which is a positive development.

5.5 On 20 October 2016 B rang Staffordshire Police and requested a 'Clare's Law' (Domestic Violence Disclosure Scheme[3]) disclosure in respect of K. An inappropriate decision within Staffordshire Police had the effect of preventing a disclosure which should have been made. The was redressed by Cleveland Police and a disclosure was made to B on 27 October 2016.

5.6 Of the 21 crimes recorded by Staffordshire Police, ten were filed prior to the death of B without prosecution of K being pursued. In eight cases the decisions taken were appropriate to the circumstances. Closure of the other two crime reports is attributable to the inappropriate approach to them taken by Staffordshire Police Officers

5.7 In the first of these, involving alleged breach of a Non-molestation Order on 5 December 2016, this was not pursued on the basis that B had spent some time at a pub with K, that K would not have known where B was without her sharing this with him and that B was therefore complicit in the breach. That K showed the Police messages on his phone which purported to be from B was accepted without further investigation as supporting this position. There is no evidence to discount that any apparent complicity by B in meeting K was the result of fear or coercion, which had been referred to by B when she reported the incident.

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[3] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance

Also, it is the responsibility of the respondent to ensure compliance with a Non-molestation Order and any apparent complicity should not be a factor in considering a breach of the Order. Further, the phone messages produced by K were identified after the death of B as having been sent by K to himself using a second phone.

5.8 In the second case, allegations on 26 and 28 December 2016 from a man who received telephone calls accusing him of being a rapist, demands for money and threats of violence, was filed as undetected on the basis that the originating phone was an unregistered mobile and there were no lines of enquiry. Information passed to the investigating Officer regarding use of the same phone to contact a friend of B on 31 December 2016 was not pursued at the time

5.9 Both of these cases represent missed opportunities to seize evidence in the possession of K and utilise criminal sanctions to curtail his offending.

5.10 The other 11 recorded crimes remained unresolved prior to the death of B and there was no effective coordination of the investigations into these until February 2017 when a supervisory rank investigator from the Force Safeguarding Investigation Unit reviewed the situation and prepared an investigation plan. A consequence of this was that in providing the background to reported offences, B and others had to repeat themselves on numerous occasions; an unsatisfactory approach to care for victims but also potentially undermining their evidence through inevitable discrepancies in successive accounts.

5.11 Even when the investigation plan was developed, an absence of specialist investigative capacity led to the investigation being allocated to a Neighbourhood Team Officer. The Review Panel was advised that the allocation process for such investigations has since changed. These are now owned by the Criminal Investigation Department and reallocation only takes place following consideration of risk and the proposed investigator's skill set.

5.12 As part of the investigation plan K was arrested on 14 February 2017 on suspicion of Stalking and Harassment. This provided an important opportunity to seize electronic communication equipment belonging to K. It is understandable that the analysis of this material would take time and would be unlikely to provide the basis for a charging decision on that date. The Police were however already in possession of evidence which could have supported such a decision in respect of earlier malicious communication offences. K was however released on bail to return to the Police station on 10 May 2017.

5.13 On the basis of her understanding of the provisions surrounding K's bail it was appropriate for B to report an alleged breach of this on the evening of 14 February 2017. The actual bail conditions did not support this, but positive action was taken to arrest K on 15 February 2017 for breaching a Non-molestation Order. After being interviewed K a decision was taken to release him without charge. On the information provided to the Police Inspector who made this decision, including the account of K, the rationale of this decision was not inappropriate. There were however opportunities for further investigation of the incident, particularly in respect of the credibility of K's account of his actions, and these should have been pursued.

5.14 The decision to release K without charge was challenged by B on 20 February 2017 under the Victims' Right to Review[4]' scheme. The review was undertaken that day by the Senior Police Officer who had previously provided advice to Police Officers on the response to the alleged Non-molestation Order breach on 5 December 2016 (see above) and who met with B on 21 December 2016 regarding that. The decision was to uphold the Police Inspector's decision. B was informed of this by telephone and a confirmation email was sent to the address from which the review request was made, albeit it seems that B did not receive the

[4] The Victims' Right to Review (VRR) scheme was launched on the 5 June 2013. The VRR Scheme gives victims the right to request a review of a Crown Prosecution Service (CPS) decision not to prosecute or to terminate criminal proceedings. From April 2015 the scheme was extended to include cases where the Police have taken the decision not to prosecute an alleged offender.

email. The Review Panel queried the appropriateness of this Senior Officer conducting the Review, given the previous direct involvement of the Officer with B, and was advised that there was nothing in the review scheme procedures to say this should not happen. The Police acknowledge however that in the spirit of independence and openness it would have been better to have passed the review request to another Officer.

6 MULTI AGENCY WORKING

6.1 B was the subject of discussion at two MARACs. By the time of the first, on 7 December 2016 in Cleveland, B had returned to Staffordshire and no action in Cleveland was required.

6.2 The second MARAC, in Staffordshire, was held on 10 January 2017. There was no input to the MARAC from key agencies and no indication that the MARAC recognised the extent of the abuse being perpetrated against B or developed a plan which would address this. The plan from the meeting contained only actions which were already part of professionals' core roles. Overall, there is no indication that the MARAC made any contribution to reducing risk to B.

6.3 The Stafford Vulnerabilities Hub was a multi-agency arrangement where statutory and voluntary organisations met weekly. B was discussed at five such meetings, in October and December 2016, before her case being closed on the basis that B was already engaged with all relevant agencies. There is no indication that discussion at the Vulnerability Hub led to any action being taken which might have addressed K's abuse of B.

6.4 In 2015 a Peer Review by Safelives[5] of MARAC arrangements in Staffordshire and Stoke-on-Trent identified strengths, but also a number of deficits, in those arrangements.

6.5 The areas for development from the Peer Review included a number of issues which were evident in the MARAC held on 10 January 2017 in relation to B:

- MARAC being seen as an end in itself rather than as part of a process, with an absence of agreed actions being monitored and their impact evaluated.
- Cases presented by the Police chair of the MARAC from a pre-prepared list of risk and trigger factors, reducing the likelihood of comprehensive and up to date information being provided by the referring agency and others.
- Delay from the index incident to the MARAC, with an absence of information sharing in the interim, and with actions to address risk being delayed on the basis of a MARAC having been planned.

6.6 The issues identified by the Peer Review, in conjunction with significant increases in the number of cases referred to MARAC, which could not be met within the existing organisational framework and resource capacity, led to consideration of alternative provision models. In 2017 implementation commenced, using pilot localities and then wider roll out, of a devolved MARAC model across Staffordshire and Stoke-on-Trent. It was intended that these arrangements would lead to more timely and effective intervention, with greater engagement of relevant partner agencies. The Review Panel were advised that indications from the pilot sites are positive and that by the end of 2019 a "Harm Reduction Hub" model will be implemented in Stafford. This will involve real time operational partnership support and management of risk, together with a locality based weekly MARAC process focussed on victim, family and offender interventions. Stalking cases identified for MARAC will be presented as Stalking and not domestic abuse so that the risk behaviours are clear to all attendees.

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[5] Previously "Coordinated action against domestic abuse" (CAADA).

7 MENTAL HEALTH OF B

7.1 It is clear that throughout the period under review B's mental health was impacted by stress and anxiety attributable to the actions of K. Further, that at times there were crises in this which seriously affected B's physical health and her ability to function socially.

7.2 Following her return to Staffordshire from Cleveland in November 2016 B confided in a friend that whilst at the Refuge in Cleveland she had taken an overdose of prescribed medication in an attempt on her life. B told her friend that she had not informed any professional about this; and she did not do so subsequently.

7.3 B registered with a new GP practice at the end of December 2016, at which point a comprehensive and effective assessment was undertaken. B was offered a referral for counselling and to Women's Aid but declined both.

7.4 On 11 January 2017 B informed her GP that she had explored suicidal ideation and the GP took the view that B had underlying post-traumatic stress. From then onwards B had seven further contacts with the same GP prior to her death. The CCG report for the Review concluded that GP engagement with B from December 2016 until her death went beyond expected standards and showed exemplary practice by the GP involved. The Review Panel concurred with this view.

7.5 On the evening of 17 January 2017 B was admitted by ambulance to County Hospital, Stafford (University Hospitals of North Midlands NHS Trust - UHNM), having reported that she had taken an overdose of prescribed and over the counter medication. There is no indication in the County Hospital records of B being asked if she had previously attempted suicide, of a reference by B to "issues in her personal relationships" being explored, or of a risk assessment being completed. B's friend informed the Review that the only risk assessment undertaken was a doctor asking B "Are you going to do it again?" Further, there is no indication that the quantity of prescription drugs which B might still have at home was explored with her as it should have been. Hospital staff did, appropriately, establish that B had no dependents at her home. B was discharged after 3 hours in the Emergency Department and a discharge summary was sent to B's GP.

7.6 The Review Panel was advised by UHNM that reference in the hospital records to B having no current feelings of self-harm, that she had an appointment arranged with MIND[6] and that she would be staying with friends suggested that B had been assessed as not requiring an urgent review by the mental health crisis team[7]. Further, that if patients are not at immediate risk then assessment at another time, rather than in the Emergency Department, may be more appropriate.

7.7 UHNM informed the Review Panel that in 2017 the Emergency Department introduced a Mental Health Assessment Tool which is to be completed by clinicians to determine patients' self-harm risk and help them decide whether further assessment is needed.

7.8 The Review Panel concluded that in the absence of an urgent referral to the CRHT Team, the most expeditious means to securing access to mental health services for B was through her GP[8].

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[6] B did not have an appointment arranged with MIND. The basis for her informing hospital staff that she did has not been established.

[7] Liaison Psychiatry for Emergency Department patients at County Hospital operates between the hours of 0800 – 1500 Monday-Fridays. If a patient requires urgent mental health support outside of these hours then staff can contact the Midlands Partnership NHS Foundation Trust Crisis Resolution & Home Treatment (CRHT) Team.

[8] The pathway for securing non-urgent access to mental health services required Emergency Department staff ask the patient to see their GP or make a self-referral.

7.9 The GP's response to learning of B's overdose on 17 January 2017 was entirely appropriate but marred by communication problems associated with the use of FAX to refer individuals to mental health services. The potential for such difficulties will be remedied by March 2020 at the latest, consequent to a direction in December 2018 from the Secretary of State for Health and Social Care that all NHS use of FAX will cease by then.

7.10 In addition to the issue with the FAX referral there were inappropriate delays in B's journey through the referral process to receiving a service, which was disjointed and marked by B herself having to chase up the referral. Midlands Partnership NHS Foundation Trust (MPFT) advised the Review Panel that the Trust has since re-designed services, with new referral pathways through a single access point[9] and active promotion of these with all other agencies.

7.11 On 20 January 2017 it was arranged that B be re-admitted to County Hospital, Stafford as she was physically unwell. At the hospital B asked to speak with the mental health crisis team and was seen at the hospital Emergency Department by MPFT CRHT staff. The arrangements made for assessment and monitoring of B over the following days were appropriate.

7.12 In a formal complaint following the death of B, a friend of hers questioned why hospital staff had to be prompted to refer B to the crisis team. UHNM advised the Review Panel that as B as had attended the Emergency Department with symptoms of a physical health condition this would be the primary concern and that a referral to the mental health crisis team would not be made unless this was prompted by B or she was assessed as requiring Mental Health service involvement. The Review Panel considered that this suggested a less than holistic approach to assessment of B when she was admitted.

7.13 Emergency Department staff were aware that B informed the CRHT staff that she was a victim of domestic abuse. Although this disclosure was made to CRHT staff who were to remain in contact with B, the hospital staff should have followed this up to ensure that appropriate referrals had been made.

7.14 The Review Panel was advised by UHNM that, since 2017, increased mental health training, including its links with domestic abuse has been put in place within the Emergency Department.

7.15 MPFT advised the Review Panel, taking into account relevant NICE guidelines[10], it was evident that B was not mentally ill but suffered from long term stress relating to her situation. A decision to discharge B on 23 January 2017 was appropriate given that B was making plans for the future and denying intent to end her life. Women's Aid had assured the CRHT team, just prior to B's discharge, that counselling sessions would commence in the near future and until then they would provide B with ongoing support.

7.16 The Review Panel discussed the use of medication to control situational stress and was advised that medication alone would not have resolved B's problems. It was important, as B's GP did, to recognise underlying abuse when considering prescription of medication for situational stress. It was however an appropriate means of assisting with the cognitive rationalisation of stressful situations by bringing an individual down from a peak of stress. It was also noted that controlled medication was a favourable alternative to sustained alcohol use which was often a resort for those suffering from high levels of stress.

7.17 When interviewed for this Review B's GP expressed concern that his attempts to contact B outside of the pre-arranged appointments may have added to her anxiety as the surgery

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[9] https://www.teldoc.org/access-service-for-adult-mental-health

[10] https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance#step-3-persistent-subthreshold-depressive-symptoms-or-mild-to-moderate-depression

telephone system withheld the caller's contact number and believes he should have made B aware of his intention to call more frequently. The Practice staff now have access to a telephone which will reveal the number to the receiving individual if this is deemed appropriate.

7.18 On 18 January 2017 B queried with a MPFT call taker whether, if she was to engage with their services, her mental health would have to be shared with the Court. B's sister informed the Review Panel that the potential impact of accessing mental health services on her credibility as a witness was a major concern for B around this time. The Review Panel took the view that this is an issue on which victims of abuse may have legitimate concerns, noting that offenders have used this to undermine victim's credibility, as well as using the threat of being undermined as a means of control. Conversely the Panel noted that a victim who does not seek mental health support when appropriate may be viewed by a court as having contributed to detriment in their welfare. Overall the Review Panel concluded that a blanket approach to this could not be taken and that any situation had to be considered individually.

7.19 Staffordshire Police were aware on 17 January 2017 of B's admission to hospital that day having attempted to take her life and there was further contact with other agencies between 18 and 23 January 2017 during which this was discussed. There is however no indication that this was explicitly considered in relation to the likely impact of subsequent Police contact with B (on 9 January, 1 February and 14 – 17 February 2017), in formulation of the investigation plan agreed on 8 February 2017, or when the Senior Police Officer contacted B on 20 February to advise that her Victims' Right to Review application was unsuccessful. Staffordshire Police advised the Review Panel that, as a result of changes to the force response to Stalking, B would now be classed as a high-risk victim.

8 MENTAL HEALTH OF K

8.1 Following a report to Police on 18 February 2017 of concern that K may harm himself the Officers investigating him visited the hotel where he was staying and then arranged for him to be assessed by a MPFT Police Liaison Community Psychiatric Nurse (CPN). This led to him being admitted to Harplands Hospital (North Staffordshire Combined Healthcare NHS Trust-NSCHT), Stoke-on-Trent, as an informal patient, on 20 February 2017. K was discharged from Harplands Hospital, at his own request, on 1 March 2017.

8.2 The Review Panel was advised that there were no grounds upon which K could have been detained under the Mental Health Act, 1998 and that the treatment provided to K by mental health services was appropriate to his presenting condition.

8.3 In the assessments documented by both MPFT and NSCHT it was recorded that K was the subject of a Non-molestation Order and that K had disclosed his arrest and conviction in November 2016. The circumstances of this were however minimised by K and overall he portrayed himself as a traumatised victim of B's behaviour. In this regard the significance of the Non-molestation Order, and K having breached it, as indicators of K's culpability were not recognised by staff at Harplands Hospital. Consequently only a generic risk assessment was carried out, without completing the additional tool available for assessment of domestic abuse risk.

8.4 The Review Panel was advised that by NSCHT that recognition of the Non molestation Order's significance would have led to greater consideration of risk to K's ex-partner, with whom he went to stay following his discharge, and multi-agency ways in which this might be addressed. The NSCHT report includes a recommendation for action to ensure that their staff are aware of the significance of protective Orders.

9 STALKING

9.1 A final section of the Review report considers responses to Stalking; and service developments within Staffordshire since 2017, consequent to a joint thematic inspection[11] by HMIC[12] and HMCPSI[13] and learning from the events examined as part of this Review.

9.2 The Review Panel noted that in considering risk to victims of Stalking it is particularly important to recognise that the victim's subjective feeling of safety/risk is as significant as their objective safety. In respect of B there were many occasions when this did not happen, with decisions about risk being focussed on issues such as the physical location of B, whether K knew where she was and whether measures to increase her physical security were objectively required. The Review Panel considered whether the risk assessment tools used adequately promoted consideration of whether and why a victim may feel unsafe. In this regard the Review Panel saw a move by Staffordshire Police to using the DASH risk assessment model, including the availability of the S-DASH (stalking) variant, as a positive development.

9.3 B was advised on a number of occasions, by Police and Refuge staff, to close her social media accounts and change her telephone number in order to thwart K's ability to communicate with her. B did make some moves to limiting her direct exposure to social media and left her mobile phone with a friend when she travelled to the Refuge. In addition to receiving direct communication from K, B was also however informed by her friends of social media posts and of calls made to her phone which she left with them.

9.4 B reported being terrified of going offline because she would not know what K was doing and thought that this would increase the risk to her family. The Review Panel concluded that for B to hold and be guided by this view was understandable. Further, that although sharing K's communications with B might be viewed as being complicit in the abuse of her, it was fully understandable that B's friends would support her position. The Review Panel noted that this is reflected in the current position of Staffordshire Police, highlighted in their Vulnerability Toolkit, that blocking may lead to isolation of the victim and increase the risk of contact offending but the decision on whether to block devices is the victim's choice.

9.5 Most importantly the Review Panel took the view that the primary focus of responses to Stalking should be to recognise the serial nature of the offending and to stop the offender's behaviour, thereby removing the victim's need for protection, support and to change their behaviour. The framework for this does exist, through effective use of criminal investigation, bail conditions and Court sanctions, the use of protective Orders (including Stalking Protection Orders and to be further enhanced within the forthcoming Domestic Abuse Bill), and robust management through local multi-agency partnerships, including MAPPA. This mindset was not however evident in the response provided by agencies in contact with B, and in some instances the view that B had taken action to protect herself worked to undermine it. For example, the Review Panel considered that B should not have had to go to a Refuge; intervention with K should have provided her with protection without doing so. That B had sought Refuge away from Stafford however led to Police inaction on the basis of there being no immediate risk of physical harm. It is positive that an underlying ethos of wide-ranging developments in the Staffordshire response to Stalking, documented in section 17 of the Review overview report, is to address the above issue.

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[11] Living in Fear – the Police and CPS Response to Harassment and Stalking. https://www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/living-in-fear-the-police-and-cps-response-to-harassment-and-stalking.pdf

[12] HM Inspectorate of Constabulary.

[13] HM Crown Prosecution Service Inspectorate.

LEARNING AND RECOMMENDATIONS

9.6 The following were identified as the main leaning points from this Review:

- All professionals who have contact with vulnerable people should be aware of Stalking and the services available for victims of it.
- The primary focus of responses to Stalking should be to recognise the serial nature of the offending and to stop the offender's behaviour, thereby removing the victim's need for protection, support or to change their behaviour.
- Reports of Stalking should be recorded as such to reflect and promote recognition of an ongoing course of conduct by the offender, its impact and the associated risks to the victim, their family and friends.
- The funding model for refuges, classed as supported housing and with a shortfall in grant and charitable donation funding, is likely to deter victims who are not in receipt of state benefits from accessing the protection they need.
- Where a victim reports a succession of incidents there are likely to be inconsistencies in the accounts given and the responses to risk assessment questions, reflecting both the nature of the index event but also conscious or unconscious assumptions that professionals would be aware of previously imparted information.
- The use of telephone systems which withhold the caller's number to contact victims of Stalking and other abuse, may be both ineffective and cause the victim anxiety. Making available a telephone number which is not withheld to relevant professionals should be considered.
- Professionals working with adults who may be victims of abuse should be fully aware of protective Court Orders which are available and the significance of these as indicators that an individual may be at risk or pose a risk to others.

9.7 Taking into account the significant developments in services since the events examined by this Review the Review Panel made the following recommendations:

1. ***That Staffordshire Police should remind all Senior Officers and staff with responsibility for determining Right to Review applications of the importance of independence and transparency, and to consider the impact on this of any previous involvement with the individuals or case concerned when deciding who should undertake the review.***
2. ***That the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should consider current arrangements for engaging GPs in the multi-agency response to domestic abuse and what developments may optimise the benefit of such engagement.***
3. ***That the Stafford Community Wellbeing Partnership seek assurance from UHNM on the uptake and effectiveness of Emergency Department training in recognition of and response to patients with mental health problems, and that their arrangements for risk assessment and provision of access to mental health services are robust and being applied consistently.***
4. ***That the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board should promote professional awareness of available protective orders and the significance of these as indicators of risk.***

9.8 Recommendations for action to improve services were also made by agencies which contributed to this Review and the Independent Office for Police Conduct. These are provided at Appendix B to the overview report.

9.9 Implementation of action plans arising from recommendations of the Review Panel and the contributing agencies will be monitored under arrangements agreed by the Stafford Community Wellbeing Partnership.