Safer Somerset Partnership

Domestic Homicide Review

Report into the death of Alicia

Date of Death: June 2021

Contents

Domestic Homicide Review

Overview Report

Safer Somerset Partnership

Report into the death of Alicia

June 2021

Author – Dr Shonagh Dillon, LLB, DCrimJ

January 2025

Contents

Glossary

AAFDA – Advocacy After Fatal Domestic Abuse

ACES – Adverse Childhood Experiences

A&SC – Avon and Somerset Constabulary

BPD – Borderline Personality Disorder

CCB – Coercive and Controlling Behaviour

CCG – Clinical Commissioning Group

CIN – Children in Need

CJS – Criminal Justice System

CPS – Crown Prosecution Service

CSC - Children's Social Care

CSP – Community Safety Partnership

DA – Domestic Abuse

DASH – Domestic Abuse, Stalking and Honour Based Violence

DHR – Domestic Homicide Review

EDT – Emergency Duty Team

EUPD – Emotional Unstable Personality Disorder

GP – General Practitioner

HO – Home Office

HV – Health Visitor

ICB – Integrated Care Board

IDVA – Independent Domestic Violence Advocate

IMR – Individual Management Review

LSU – Local Safeguarding Unit

MARAC – Multi-Agency Risk Assessment Conference

MASH – Multi-Agency Safeguarding Hub

MIU – Minor Injuries Unit

NFA – No further Action

NHS – National Health Service

NMO – Non-molestation Order

OIC – Officer in Charge

PCC – Police and Crime Commissioner

PHN – Public Health Nursing

PNC – Police National Computer

PSED – Public Sector Equality Duty

PTSD – Post Traumatic Stress Disorder

RO – Restraining Order

SDA – Stop Domestic Abuse

SFT – Somerset NHS Foundation Trust

SIDAS – Somerset Integrated Domestic Abuse Service

SPO – Stalking Protection Order

TOR – Terms of Reference

VAWG – Violence Against Women and Girls

UNODC - United Nations Office on Drugs and Crime

WHO – World Health Organisation

Domestic Homicide Review Overview Report into the death of Alicia:

Tribute:

I want to honour the life of my daughter, Alicia, a light that will forever shine in my heart. Though she is no longer with us, the memories she left behind will continue to fill me with love, warmth, and gratitude for the time we had together. Alicia was more than my daughter—she was my joy, my laughter, and a part of my soul that will always remain.

From the moment she came into this world, Alicia brought a sense of wonder and happiness to those around her. She had a beautiful smile that could light up any room, and her laughter was infectious. She had a way of making even the smallest moments special, like how she'd dance around the kitchen when a song she loved came on, or the way she'd curl up with a book, completely lost in its pages, only to stop and share a story with such enthusiasm. Her love for life was evident in every little thing she did.

One of my fondest memories is watching Alicia grow into the remarkable person she became. She was full of creativity and curiosity. As a child, she loved to draw, filling page after page with her vibrant imagination. She had a way of seeing beauty in the world that others might overlook, and she expressed that beauty in everything she did. Whether it was through art, her love of nature, or the way she cared for those around her, Alicia had a heart that was open and generous. She cared for so many people and would randomly chat with strangers.

Alicia was someone who embraced life fully. She loved just talking about everything and nothing. I remember the joy in her eyes when she saw something new, whether it was a beautiful sunset, the moon, or simply the beauty of the world around her. Those are the moments I will carry with me forever—the sound of her voice, the way she would point something out with such excitement, and the joy of simply being with her and dining on her incredible roast dinners.

There are so many little things I miss—her gentle teasing, her phone calls just to check in, and her thoughtful nature. Alicia was the kind of person who would go out of her way to make someone feel loved. She never missed a birthday, and her gifts were always chosen with such care, reflecting her deep understanding of what made each person special. Her kindness wasn't something she reserved just for those closest to her—it was something she extended to everyone she met.

Though her journey ended far too soon, the love, laughter, and joy she brought into our lives will never fade. I will always remember Alicia as the incredible daughter. She had her struggles but those do not define who she was. What defines her is her love for her children, her passion, her creativity, and the way she touched everyone she met.

Alicia, I miss you more than words can say. You will always be my little girl, the one who brought so much happiness into my life. I will forever cherish the memories we created, the laughter we shared, and the love that will never leave my heart. I hope you have found peace, my sweet Alicia, and know that you are remembered every day with love.

Dad

I hope that this report will highlight the need for better multiagency understanding about the impact of stalking, by raising awareness, preventing harm, and addressing dangerous behaviour before it escalates.

Preface

The independent author, Domestic Homicide Review (DHR) panel and the Somerset Community Safety Partnership (CSP) wish to offer their deepest condolences to everyone who was affected by Alicia's[1] death. We extend our further thanks to those who knew Alicia and contributed to this review, their generosity in doing so, considering their loss, is greatly appreciated.

In addition to this the author and the panel would like to extend our thanks to all professionals who responded to the Individual Management Reviews (IMR), the time and effort taken to complete these to a good standard enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincere thanks to the panel members for their professionalism and the considered manner in which they approached this review.

1. Introduction and Background

1.1 This review will examine the circumstances surrounding the death of Alicia, aged 34, who died by apparent suicide in June 2021.

1.2 Domestic Abuse Related Death Reviews (DHRs) came into force on the 13th of April 2011.They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by-

[1] Not her real name

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death[2].

1.3 The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

2. Timescales

2.1 This report of a death, where domestic abuse was identified, analyses the involvement and responses afforded to Alicia, who was a resident in Somerset at the point of her death in June 2021.

2.2 The review will consider agency contact with Alicia and two of her ex-partner's Mark and Simon[3] for the period of:

- January 2016 to June 2021

This time frame was agreed to be appropriate by all panel members in December 2021.

The referral from Somerset NHS Foundation Trust was sent to the CSP in June 2021. The decision to undertake a DHR was made by Somerset (CSP) on 25th July 2021. The Home Office was subsequently informed.

---

[2] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

[3] Not their real names

An independent chair was appointed by the Safer Somerset Partnership (SSP) in October 2021. Unfortunately, after commencing the review, the independent chair experienced a succession of significant personal issues, and despite extensive efforts and negotiations between the Safer Somerset Partnership and this chair to conclude the review, the decision was made in Spring 2024 that the former chair could not complete the review.

In May 2024 the CSP re-commissioned the DHR to a new chair, Dr Shonagh Dillon who undertook the role of independent author and chair to the panel and the DHR panel was re-convened. Due to the delay in the review being completed Dr Dillon made the decision to write a draft review before meeting with the panel to discuss the analysis and recommendations of the review. The purpose of this was to prevent any further delay with the coroner's inquest and most importantly to prevent any further delays for the family, who the panel all agreed have waited far too long for the closure of this review.

The panel members met on the following dates:

- DATES (previous chair) 16th December 2021, 18th March 2022, 12th May 2022, 27th July 2023

- Dates (second chair) 28th August 2024, 9th December 2024.

2.3 The overview report and executive summary were presented to the SSP CSP board for approval on 8th January 2025 and submitted to the Home Office on 13th February 2025. The report was considered by the Home Office Quality Assurance Panel on 30th September 2025 and approved for publication in November 2025.

3. Confidentiality

The Individual Management Reviews (IMR) will not be published but the DHR report will be made public.

The contents of this report are anonymised to protect the identity of the deceased, family, friends, staff, and others to comply with the Data Protection Act 2018[4].

4. Methodology and Terms of Reference

[4] https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

4.1 Following the decision to conduct this DHR, the panel were provided with a timeline of the case. Subsequently, several other statutory and voluntary sector agencies were asked to return a chronology of their involvement to help the panel understand and analyse any interactions agencies had with Alicia, Mark and Simon during the specified review period.

Having considered the chronologies, the following Individual Management Reviews (IMRs) were requested:

a) Avon and Somerset Constabulary
b) Public Health Nursing
c) Somerset Clinical Commissioning Group
d) Somerset NHS Foundation Trust
e) Children's Social Care
f) SIDAS Livewest (contracted provider until 31.3.2020)
g) SIDAS The You Trust (contracted provider post 1.4.2020)
h) Stop Domestic Abuse

4.2 The Terms of Reference guidance set out the purpose and the scope of the review. The panel focused on the following questions for analysis, and they will be referred to throughout the review:

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family

in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Consider whether the Covid-19 pandemic affected the accessibility of services for Alicia and her family.

The authors of the IMRs are independent in accordance with the Home Office guidance[5].

The full Terms of Reference are available in Appendix A of this report.

4.3 This report is based on:

- The combined chronologies of all agencies
- The findings and panel analysis of the IMRs
- Interactions with Alicia's family

Each IMR author offered single agency recommendations which are presented in section 16 of the report. The panel have reflected and amended where they felt that single agency actions needed further clarity.

The full recommended action plan is presented in section 16 of this report.

The conclusions and recommendations are the collective views of the Panel, which has the responsibility, through the participating agencies, for implementation of any improvement recommendations.

4.4 <u>People involved in the DHR:</u>

---

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DARDR-Statutory-Guidance-161206.pdf (Section 7)

Name	Age at time of death	Relationship with the victim	Ethnicity
Alicia	34	Victim	W/B
Mark	34	Alleged Perpetrator	W/B
Simon	34	Alleged Perpetrator	W/B

Children

Child 1	Birth year - 2006	Parents – Alicia & Other
Child 2	Birth year - 2008	Parents – Alicia & Mark
Child 3	Birth year - 2013	Parents – Alicia & Mark
Child 4	Birth year - 2016	Parents – Alicia & Simon
Child 5	Birth year - 2019	Parents – Alicia & Simon

The panel has applied the Home Office guidance and has given the pseudonyms identified above to the offender and the victim. It is hoped this humanises the review process and eases the reading of the report. The friends and family of Alicia were happy with the name chosen for her.

5. Facts

Alicia was a 34-year-old female, who had an extensive history of being subjected to domestic abuse and stalking from both her previous partners, Simon and Mark. Alicia was known to mental health services and had been given a diagnosis of borderline personality disorder (BPD) in January 2020. BPD is also referred to as emotionally unstable personality disorder (EUPD), with rapid mood changes. Her initial relationship with Mark resulted in them having their children removed into local authority care, where they remained until her death. The reasons for the removal of her children included the domestic abuse she was being subjected to from Mark. In 2014 Alicia met Simon and agencies first became aware of her as a victim of domestic abuse from Simon in 2016. From that time on until July 2019 services worked with Alicia and Simon to address his abuse towards her and the impact on the children.

From July 2019 until March 2020 Alicia had a period of stability in her life with no further reports of domestic abuse. But in March 2020 Mark started a campaign of stalking Alicia after eight years of no contact with her. The stalking continued until her death in June 2021.

During the last year of her life Alicia's mental health declined and she found it hard to cope with three young children, one of whom had a diagnosis of autism. It is clear Alicia loved her children very much, but in May 2021 Alicia was taken to a place of safety on a mental health inpatient unit where she was assessed and admitted. In June 2021 Alicia died by apparent suicide, may she rest in peace.

6. Involvement of Family and Friends

6.1 **Victim**

The former chair had some contact with the family, and the second chair contacted Alicia's family in May 2024 as soon as she was commissioned. Both Alicia's mum and dad were kind enough to meet the chair. Alicia's dad and the chair corresponded via email and met via video call during the timeline period. Alicia's mum was supported by an advocate from the organisation Advocacy After Fatal Domestic Abuse[6] (AAFDA), the chair met with Alicia's mum once via video call and subsequently all correspondence was filtered through the advocate.

Both parents were invited to meet with the panel, but this invitation was not pursued.

Subsequently Alicia's sibling gave the chair their thoughts. The family views on what happened for Alicia differ at points with regards to the position of the parents this has therefore been presented separately to ensure their voices are heard.

6.2 **Perpetrators**

The chair of the panel was put in touch with Simon via a family member in August 2024. Simon and the chair spoke by phone, and he expressed a desire to be involved in the review. However, subsequent contacts from the chair to Simon were not responded to.

After a detailed risk assessment, the panel made the decision not to contact Mark to gain his perspective.

The review is therefore limited from the perspective of the alleged perpetrators in this case.

6.3 **Children**

The chair of the review contacted the social worker for child 1 and 2 via letter. The option was given to them on whether they wanted to be involved in the review. After liaison with the social worker the chair wrote a list of guided questions that may be asked, and also offered the option of child 1 and 2 giving their own thoughts in any way they preferred. Ultimately child 1 and 2 decided not to be involved in the review process. The final published report will be sent to their social worker should they want to read it at a later date.

After liaison with the relevant social worker, it was assessed that speaking to child 3 about her mum would be too deregulating for her. The chair of the review therefore organised for the published report to be sent to the social worker and kept on file for child 3.

Child 4 and 5 reside with Simon and the chair explained to him the children could be involved in the review if they chose to and in any way that they wanted, including providing pictures or just their thoughts. Simon said he would consider this, however, as no further contact was achieved with Simon child 4 and 5 were not involved in the review.

[6] https://aafda.org.uk/

As a result of the above the children's voice is limited in the overall report.

7. Independence

7.1 The chair of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

Dr Dillon is a Home Office accredited DHR chair and has nearly three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. It is worth noting that the IMR author for CSC was line manager for one of the social workers and the team manager, but she did not have direct contact with any of the subjects and her independence was agreed by the previous chair. None of the other panel members were the immediate line managers of anyone who engaged with Alicia, Mark, or Simon.

8. Domestic Homicide Review Panel

The DHR panel consisted of the following agencies and professionals:

Panel Members
Chair and Author – Dr Shonagh Dillon, LLB, DCrimJ
Somerset NHS Foundation Trust - Strategic Lead & Named Professional for Safeguarding Adults
Children's Social Care – Strategic Manager Operations Children with Disabilities
The You Trust – Assistant Director Paragon (SIDAS services) – DA expert panel member
Senior Commissioning Officer (Interpersonal Violence) Somerset County Council
Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team
Deputy Designated Nurse for Safeguarding Adults – Somerset ICB
Detective Chief Constable – Avon and Somerset Constabulary
Strategic Lead and Named Professional for Safeguarding Adults/ DASV Lead, Somerset NHS Foundation Trust

9. Parallel Reviews and Processes

9.1 A standard post-mortem was conducted in June 2021.

9.2 The Coroner's Inquest is listed for February 2026.

10. Equality and Diversity

Relevant TOR Point:

- Whether practices by all agencies were sensitive to the sex, age, disability, ethnic, cultural, linguistic, and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately, and recorded.

10.1 The Equality Act 2010 defines the following as protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

All the protected characteristics have been considered throughout this process with mental health being addressed under 'disability'. Services must adhere to the Public Sector Equality Duty (PSED)[7] and have due regard to the protected characteristics of individuals in order to harmonise equalities and foster good relations.

There are generally three aims[8] under the PSED and these involve:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

[7] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty
[8] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty

Alicia, Mark and Simon were all White British, and heterosexual, the data did not reveal that either associated with any particular religion. The following protected characteristics have been considered in the analysis of the review:

10.2 **Sex** - Worldwide, over a quarter (27%) of women aged 15–49 years who have been in a relationship report that they have been subjected to some form of physical and/or sexual violence by their intimate partner[9]. Alicia shares many of the same experiences and characteristics as the other women who are subjected to domestic abuse - the overriding factor they all have in common is their biological sex. In addition, research[10] shows that most victims of stalking are female, and most offenders are male[11]. Women are also more likely than men to experience fear due to stalking[12]. Lifetime estimates show that approximately one in five women and one in ten men experience stalking (since the age of 16)[13]. Most victims know their stalker: the largest group of stalkers (46% of all cases) are former intimate partners[14]. People stalked by an ex-partner are at greater risk of serious harm[15] and stalking is often more prolonged[16].

10.3 **Disability/ Mental health** - Protected characteristics and the discrimination people face often intersect. Alicia's presenting issues could be described as multiple and complex, when taken into context of a victim of abuse who also intermittently used substances and had mental health issues. The relationship between suicidal ideation and domestic is a growing area of research and new data reveals that women who suffer domestic abuse are three times more likely to take their own life and or use self-harm as a coping mechanism[17]. Research[18] evidences that death rates from suicide are consistently higher for men, and thus many interventions to reduce the suicide rate amongst populations are aimed at men. Although this good work should not be undermined, it means that women's experience of suicidal ideation is often side-lined. Given that women are significantly more likely than men to attempt suicide[19], responding to women's suicidal ideation should also be a priority:

---

[9] https://books.google.co.uk/books?hl=en&lr=&id=8sVqEAAAQBAJ&oi=fnd&pg=PR6&ots=bbiOx6Vti6&sig=8hq4EBtcVp_7yTx4_5rci_8zlf4&redir_esc=y#v=onepage&q&f=false

[10] https://link.springer.com/article/10.1007/s10896-020-00201-0

[11] https://doi.org/10.1177/0886260511416473.

[12] https://doi.org/10.1177/0886260511416473.

[13] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/stalkingfindingsfromthecrimesurveyforenglandandwales

[14] https://www.met.police.uk/cp/crime-prevention/harassment/af/Harassment/harassment/

[15] https://doi.org/10.1016/j.ijlp.2006.03.005.

[16] https://doi.org/10.1002/bsl.975

[17] https://www.theguardian.com/society/2023/feb/22/women-who-suffer-domestic-abuse-three-times-as-likely-to-attempt-suicide#:~:text=Victims%20of%20abuse%20by%20a,risk%20of%20having%20suicidal%20thoughts.

[18] https://journals.sagepub.com/doi/full/10.1177/0269758018824160

[19] https://journals.sagepub.com/doi/full/10.1177/0269758018824160#bibr15-0269758018824160

The role of traumatic experiences, such as being subjected to domestic abuse, as a precursor to suicidality has already been formally recognised at national (Department of Health, 2012) and international (WHO, 2014) levels. However, the scale, dynamics and complexity of this intersection, and the ways in which positive interventions may be secured, remain significantly under-researched, particularly in the UK.[20]

10.4 **Pregnancy and maternity** - Alicia had five children – two of which were removed from her care at a young age, and the last three were removed, at Alicia's request, just prior to her death. The links between the escalation of domestic abuse whilst a woman is pregnant is well established in research[21]. Throughout the world the feature of domestic abuse in pregnancy is noted as a prevalent feature[22], and it is both a serious health concern as well as a breach of women's human rights[23]. Accessing general health services is a fairly routine act during a woman's pregnancy and there were multiple opportunities for agencies to note Alicia's relevant protected characteristic during these periods in her life. The reality of the intersection of her compounding vulnerabilities should have meant professionals were alert to the further potential for oppression from an abusive partner.

Pregnant women retain a privileged public position in society, but the frequent violence some are subjected to within their homes suggests discordance in their status in public and private spheres. Officially, we are deeply offended at the image of a pregnant woman being choked or kicked in the abdomen, but this instinctive distaste produces a strong taboo, and it is perhaps this which prevents us from rigorously screening and offering intervention to this vulnerable group.[24]

11. Dissemination

11.1 Whilst it is essential to share key issues with agencies and organisations involved in this DHR, this report will not be disseminated until clearance has been received from the Home Office quality assurance group.

Once clearance has been approved by the Home Office quality assurance group, the dissemination of the overview report will be published on the Somerset Survivors website and will be widely disseminated including, but not limited to:

- Members of the Community Safety Partnership

[20] https://journals.sagepub.com/doi/full/10.1177/0269758018824160
[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442136/
[22] https://europepmc.org/article/med/16972587
[23] https://dspace.ceid.org.tr/xmlui/bitstream/handle/1/93/ekutuphane4.1.6.4.pdf?sequence=1&isAllowed=y
[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442136/

- Somerset Domestic Abuse Board
- Avon and Somerset Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- Somerset Safeguarding Children Partnership
- Somerset Safeguarding Adults Board

11.2 The Somerset Domestic Abuse Board will be responsible for monitoring the implementation of recommendations.

12. Chronology

This section is not intended to replicate the combined chronology of agencies in full, due to the large amount of data produced by agencies within the timeline period the following information represents the significant events in Alicia's life, alongside the pertinent information about Mark and Simon.

Some of the significant events occurred outside the timeline period (see 12.1 to 12.10), but due to the fact that Alicia was subjected to domestic abuse from two separate partners, both of whom she had children with, the panel felt it important to incorporate this information to add context to what had been going on for Alicia for many years. Where possible the chair has corroborated these events with family members.

- In March 2009 Alicia fled her abusive relationship with Mark, her oldest child was three and her second child was just under six months of age.

- Alicia and Mark had periods of time where they reconciled the relationship, but Mark's abuse towards Alicia continued. Alicia was known to be using class A drugs, and cannabis during this time. Children's social care became involved with the family in early 2010.

- By 2011 both child 1 and child 2 had been removed from the care of Alicia and Mark, they were placed in foster care, under the category of emotional neglect and risk of physical abuse. Family time was arranged six times a year and although Alicia expressed a desire to regain custody her visits to her older children ceased from February 2020 onwards. Alicia rejected the requirement of supervised visits, but records show that this was at the request of the children, because *'mum could be unpredictable at times'*. Both her oldest children remained with foster parents until Alicia's death in June 2021.

- Alicia discloses to her GP in September 2011 that she is scared of her ex-partner, Mark, and this prevents her from having contact with her children (child 1 & 2) because she is worried Mark is going to see her, especially as he has recently broken a restraining order against her.

- During this period until the time of her death Alicia consistently sought support for her mental health, including for anxiety, depression and substance use issues. Alicia

had periods of abstinence from drugs and alcohol when she was not in a relationship with either Mark or Simon.

- In November 2012 Alicia fell pregnant with her third child (child 3). The father of child 3 was Mark but from the time she registered her pregnancy with the GP, until her death, Alicia remained separated from Mark.

- Given the prior involvement with Children's Social Care (CSC) they remained in contact with Alicia throughout her pregnancy and conducted multi-agency working arrangements with the GP. Alicia was still using cannabis during this time and CSC undertook the appropriate child protection meetings for unborn child 3.

- Child 3 was born in spring of 2013, at her first appointment with the GP Alicia disclosed that she had been completely drug free for four months. Alicia was doing well and was being supported in a mother and baby unit, and she was intending to move back to her hometown once the placement ended.

- For the first year of child 3's life she remained open to CSC, with an interim supervision order granted in respect of child 3. Alicia continued to have contact with child 1 and 2 who were in foster care, her progress was sometimes hindered by Mark's behaviour; by September 2013 child 3 was closed to CSC and they reported having no concerns regarding Alicia's parenting.

- The next significant incident recorded involved a call to the police at Alicia's home in December 2015. Alicia was with a new partner, Simon, and she reported he had broken into her house after they had an argument and smashed things up. Both CSC and Avon and Somerset Constabulary (A&SC) noted that although child 3 was in the property at the time, Alicia acted protectively towards the child and the threshold for any CSC intervention was not met. The incident Simon subjected Alicia to was referred to a Multi-agency Risk Assessment Conference (MARAC), and Alicia's details were referred to the local Independent Domestic Violence Advocacy (IDVA) service, run by Somerset Integrated Domestic Abuse Service (SIDAS).

The following chronology data involves significant events within the review timeline period of January 2016 to June 2021. For reference the SIDAS service was transferred from one provider to another in August 2019, after a change in contracts. Therefore, Alicia was provided a service via Livewest[25] between January 2016 and August 2019 and post August 2019 until her death in June 2021 any service she received from SIDAS was delivered by The YOU Trust[26].

- In January 2016 Alicia had her first contact with her Livewest SIDAS IDVA. She reported that she had been together with Simon for approximately two years, and he had been abusive for about four months. At the time of contact Alicia hadn't seen

[25] https://www.livewest.co.uk/my-home/solve-an-issue/domestic-abuse
[26] https://theyoutrust.org.uk/new-somerset-domestic-abuse-support/

Simon for about a month and she had no intention of resuming the relationship. Alicia undertook a DASH risk assessment with SIDAS, and she disclosed she had been subjected to strangulation by Simon during this incident, she also explained that she had previously completed the Freedom Programme[27], a course designed to support victims to understand the patterns of domestic abuse. Alicia was deemed to be at high risk of serious harm or murder from Simon.

- In February 2016 there was a further incident of DA from Simon towards Alicia, on this occasion a neighbour reported a disturbance at the property and the police were called, but Alicia did not make a complaint herself. The police updated CSC and the MARAC.

- In early April 2016 agencies became aware that Alicia was pregnant with Simon's child (child 4), and they were back together. SIDAS had not been able to make contact with Alicia so they spoke to Alicia's health visitor and explained they would have to close her file.

- A few days later Alicia made contact with the SIDAS service and stated that she and Simon were not living together. Alicia explained that CSC were taking her to court and that she was concerned she would lose another child to the care system due to domestic abuse. SIDAS gave Alicia the details for a perpetrator programme that Simon could self-refer to.

- By the end of April Simon had been abusive towards Alicia again, this time he refused to leave her home, so Alicia called the police. Alicia ended the relationship and CSC noted that the concerns regarding domestic abuse and substance use they had were lessened. Alicia engaged with LiveWest SIDAS and they arranged a face to face appointment with her after she explained she would prefer to see someone in person. There were no crimes disclosed in relation to this incident, so the police referred the information to the relevant agencies including CSC.

- Between May and June 2016 Alicia reported to the SIDAS service that she was happy and enjoying being a mum. She said that there had been no issues between her and Simon and they were keeping things civil regarding the custody of their unborn child. Alicia also explained that child 3 was being tested for non-verbal autism and she knew that child 3 needed a calm and stable environment and Simon was not going to give them this.

- In August 2016 during her pregnancy with child 4 Alicia sought support for her mental health, expressing concern to professionals that she may be bi-polar. She was referred to the mental health team but subsequent appointments were cancelled by Alicia. Child 3 remained on a Child in Need (CIN) plan during this time and CSC continued to monitor the safeguarding needs for child 4 as an unborn. In this period Alicia's trust of professionals declined after a social worker and midwife said Alicia

[27] https://www.freedomprogramme.co.uk/

had cancelled the appointment with the mental health team. Alicia felt she wasn't trusted by professionals, and she withdrew support for the CIN plan, and the case was closed to CSC.

- In October 2016 Alicia gave birth to child 4 and by November 2016 Alicia was engaging well with her GP. They discussed Alicia's previous experience of post-natal depression and checked in with her regarding her support network, which Alicia said was good, as she was getting help from her mum. The GP commented on how well Alicia presented and that she was not using alcohol or drugs and was eating well. At this time Simon was sharing custody of child 4 and Alicia reported that things were amicable between them.

- In January 2017 the health visitor chased the mental health appointments for Alicia, but during January, February and March Alicia was unable to make these appointments. The mental health team closed her file noting that since August 2016 Alicia had been unable to make the five appointments offered to her.

- In February 2017 a reported incident to the police noted an argument between Alicia and Simon over food for child 4. However, no direct complaints were made and therefore no crime was recorded. The GP recorded a note on the system stating the safeguarding concerns for child 3 and child 4. Child 4 was noted to have had a period of time living with Simon as Alicia was finding it hard to cope, but Alicia had child 4 back in her care and the concerns related to the fact child 3 had significant needs.

- In August 2017 Simon was charged by the police with four crimes of assault and harassment after breaking into Alicia's flat whilst she was watching TV with a friend. Simon was noted to be drunk and he assaulted both Alicia and her friend, he also reportedly called Alicia a *"whore"* and a *"skank"*. Alicia protected the children, and a CSC case file was opened but there were no safeguarding concerns noted. All four charges were dropped by the CPS due to Alicia not attending court. A DASH was completed and graded as medium.

- Following this incident, the health visitor referred Alicia to MARAC, but the referral was rejected by the SIDAS team. The health visitor re-submitted the MARAC referral, but it was again rejected by SIDAS after they assessed that the case did not meet the MARAC threshold due to the incident being related to a third party. The records evidence email exchanges between SIDAS and the health visitor until October 2017. SIDAS did speak to Alicia in September and October 2017, but she stated she did not need support and was concerned about having CSC and police involvement as she didn't want to lose her children.

- In October 2017 there was a further incident reported to police when Simon had become abusive and refused to leave Alicia's flat. Both child 3 and 4 were present. Alicia declined the option to undertake a DASH risk assessment, and the officer graded it as standard. No offences were recorded, and referrals were made to CSC and the LSU. At this stage the previous charges against Simon were still proceeding through the Criminal Justice System (CJS) and the charges had not yet been dropped.

- In November 2017 the school for child 3 found cannabis in her pencil case, which precipitated a child protection conference. A further report in November was made to the police via a third party. The report stated that Alicia had left child 3 alone in the property and child 3 was heard crying. Child 3 and 4 were placed back on a child protection plan in December 2017 and Simon was described as *'very violent and controlling'*.

- In February 2018 there was a dropped 999 call from Alicia's house. On arrival the police state that Alicia did not want to say exactly what happened, but just that she and Simon had an argument. Both the children were present and safe, and the officer graded the incident as standard risk on professional judgement.

- A month later in March 2018 police spoke to Simon after he continued to turn up at Alicia's address without her consent. There was no crime recorded but all safeguarding measures were put in place for Alicia and the children.

- In May 2018 Alicia attended the minor injuries unit (MIU) with a head injury. She explained that Simon had hit her head against a door frame. Alicia told the staff at the MIU that she was going to report the incident to the police and would stay with a friend for a few days and had good family support. No DASH was offered, and no advice or support numbers were given to Alicia at the MIU.

- The police attended Alicia's property after her report, and she was reluctant to let an officer into her property. Officers did gain entry and were concerned about the state of the property and Alicia's ability to cope. Alongside referrals to CSC, the police assessed the above incident at medium risk and referred Alicia to the SIDAS service via the Lighthouse Safeguarding Unit (LSU). When SIDAS spoke to Alicia she was unhappy that the police did no arrest Simon as he had broken into her house, and she described being *"very frightened of him"*.

- SIDAS assigned an Independent Domestic Violence Advisor (IDVA) to work with Alicia, and she positively engaged with the service on the first call. Alicia was anxious that Simon would return to her property, and she discussed repairs to her back door with the IDVA and agreed she would contact her housing provider to fix the frame on the door as it was warped. Alicia told her IDVA she wanted an order to prevent Simon from attending her property but said she thought she wouldn't get legal aid. Alicia described *"taking a knife out"* to Simon in defence and it really scared her as she could have killed him. Four further attempts to contact Alicia were made but the IDVA service didn't manage to get hold of her. SIDAS closed her case in July 2018 due to *"non-engagement"*.

- In June 2018 a child and family assessment was completed by CSC. The records state that Alicia has tried to put boundaries in place with regards to Simon and that her history of being subjected to DVA was causing her significant distress. Even though Alicia was trying to have a complete break from Simon, this was not possible due to

the contact with child 4. The children were still deemed to be at risk of witnessing DVA from Simon.

- In July 2018 there was a verbal argument reported to the police from a third party where Simon was deemed to be the victim, after Alicia had hit him on the head with something and tried to smash the windscreen of his car. Alicia was reportedly under the influence of alcohol and the report states that Alicia had pushed child 3 over trying to get to Simon, and both children were distressed. A DASH was completed, and Simon was assessed to be high risk, with a referral being sent to MARAC and information shared with CSC. The referral was rejected by SIDAS after an assessment revealed the history of Simon's behaviour towards Alicia. SIDAS could not contact Simon without his direct consent, and they noted her side of the incident may reveal who is the *'real victim'*.

- In August 2018 Alicia attended a dental appointment for child 3 and Alicia was noted to have bruises on her face and arms, which she said was from an assault at work (Alicia was a mental health support worker). A referral was made by the dental surgery to CSC as they were concerned about both child 3 and her vulnerability due to autism as well as Alicia's vulnerability of being a victim of DVA.

- In September 2018 Alicia went to see her GP and reported severe anxiety due to multiple stressors, including both her older children (child 1 and 2) being in foster care, and child 3 being diagnosed with autism. Alicia said she had hoped to get all the children together, but CSC had prevented this due to child 3's needs.

- In October 2018 Alicia informed her GP that she was back together with Simon. CSC continued to monitor the family and assessed the children to be more settled, citing the fact Simon had given up cannabis and had a new job. However, later in October a further incident was report to the police where Alicia had found out that Simon was sleeping with her friend and whilst under the influence of alcohol, she had assaulted Simon by cutting his lip. Police noted a number of bruises on Alicia's arms which she said were caused by child 3 due to her autism. No further action was taken against Alicia.

- In November 2018 Alicia had an appointment with her GP for chronic anxiety. Alicia referenced the above incident, and said she had ongoing worries about child 3's autism.

- In December 2018 and January 2019 there were a further two reports of DVA to the police. Both were listed as verbal incidents with Simon as the perpetrator and Alicia as the victim. In the first incident a third party reported and neither Alicia nor Simon would speak to the police about what happened. The second incident was reported by Alicia when Simon refused to leave the property. When officers attended Simon left and Alicia declined to report any incidents to the police or undertake a DASH.

- In March 2019 the police were called by both Simon and Alicia. Alicia was three months pregnant with child 5 and Simon had assaulted her. An ambulance was also

called to the property and Alicia was checked over by the crew. Alicia described Simon preventing her from leaving the property and grabbing her by the neck to pull her to the ground then kicking her to the face and stomach. Alicia escaped to a neighbour's house where the police were called. Although the police pursued a charge of assault, criminal damage, and theft of a mobile phone against Simon, he made counter allegations against Alicia stating she had attacked him whilst drunk, and he showed the police scratches to his neck and a mark on his back which he said was caused by Alicia biting him. When the police spoke to Alicia at the incident she showed no signs of being drunk, but described her as being *'pretty manic'*. The CPS made the decision not to proceed with a case against Simon due to the counter-allegations. Referrals were made to MARAC, SIDAS and CSC.

- Alicia engaged with SIDAS on one occasion prior to MARAC, but the file was subsequently closed in June 2019 after the service was unable to contact Alicia.

- In April 2019 Simon attend Alicia's property to see child 4. Usual contact arrangements were via CSC due to the DVA and Alicia denied Simon entry to her house. A report was made to the police, but no offences were committed and therefore no further action was taken against Simon. CSC and SIDAS were informed.

- In May 2019 Alicia saw both her health visitor and her GP. She told the health visitor that she was anxious about the birth of child 5 because it had been an unplanned pregnancy, and she informed her GP that she had been having suicidal thoughts about throwing herself under a train or a bus. Alicia described her protective factors against suicide as being her children as she didn't want to leave them, and she said she had good family support. It was noted that Alicia had an appointment with a psychiatrist through perinatal mental health support and that the history of DVA Alicia had been subjected to was having an impact on her. Alicia agreed to regular medication reviews of the anti-depressants she was taking, and she continued to engage well with the support she was offered by the mental health teams over the spring of 2019.

- In June 2019 Alicia requested that the child protection plan was not stepped down by CSC due to ongoing threats from Simon. She also requested that Simon was not told about her mental health challenges.

- In July 2019 the psychiatric nurse from the mental health team was due to do a home visit with Alicia. On arrival she noted a male shouting through the letter box. This was referred to CSC.

- A few days later another report was made to the police. Simon had tried to gain entry to the property by kicking Alicia's back door in. The police referred the case to MARAC and SIDAS and noted that a non-molestation order (NMO) had been granted against Simon but had not been served.

- Within an hour of the NMO being served on Simon, he breached it. The police arrested Simon with the breach, and he was charged with the offence. CSC referred the case

to MARAC and the SIDAS team. Although Alicia was resistant to completing the DASH form or working with SIDAS, she did consent to the social worker filling out the DASH without her input. The DASH described Simon as *"excessively jealous"*. The social worker described how in the past Alicia would always say she "*gave as good as she got"* and "*wasn't scared"* of Simon, but more recently she had been being more honest about her fear and the power imbalance between the two of them. The social worker also noted that Simon was angry at Alicia and there was a risk of a further breach of the NMO, as well as further violence from him. It was remarked upon what a significant step it was for Alicia to pursue the NMO, and that she was working well with the mental health team.

- In October 2019 child 5 was born.

- During October and November 2019, the mental health team liaised with Alicia and noted they had no concerns for her mental state, and they observed the children were doing well.

- In November 2019 a child and family assessment was completed by CSC and they observed Alicia prioritising the children over her relationship with Simon. Alicia had support from family with the children and the NMO was still in place. Due to Alicia's marked improvement in her parenting and her mental health the CP plan was stepped down to a Child in Need (CIN) plan.

- In December 2019 the mental health team shared information with CSC that Alicia had cancelled a number of appointments and historically this meant that she may not be coping.

- By January 2020 the mental health team had resumed some contact with Alicia and she was taking her medication after a period of not taking it. Alicia told the mental health team that Simon was having some contact with child 4 but not with child 5.

- In February 2020 the child in need plan ended due to no further concerns regarding the children. By March 2020 Simon was having weekend contact with child 4 and 5, there had been no reports of DVA logged against Simon since the conviction against him for breach of NMO in July 2019, and there were no further reports against Simon prior to Alicia's death.

- In March 2020 Mark began a campaign of stalking and harassment against Alicia that would continue until her death in June 2021. By this stage Alicia had not had any contact with Mark for eight years. Mark doctored images of Alicia and sent it to the police claiming Alicia had been selling indecent images of herself where she pretended to be a child.

- In March 2020 the UK went into the first COVID19 lockdown period.

- CSC were also contacted by Mark in March 2020 in his campaign of stalking against Alicia. In total Mark contacted CSC 14 times, sometimes twice in one day. These calls

were shared with the police. Mark would claim that Alicia was putting her children at risk, selling pornographic photographs of herself and taking drugs. CSC informed Alicia of the allegations, she denied the allegations and correctly identified that they were coming from Mark because he had also been in contact with one of her family members.

- In April 2020, during the COVID19 lockdown Alicia expressed anxiety about sending child 3 to school. Records show that child 3's attendance at school dropped off.

- In April 2020 Mark called the police claiming Alicia had posed as a social worker to gain access to his medical records. The claims were unsubstantiated, and no action was taken. Later in April Alicia contacted the police to log a complaint against Mark. Alicia told the police that Mark had contacted her workplace and CSC making false allegations about her. The police gave Mark 'words of advice'.

- In May 2020 CSC called a strategy meeting to assess the claims Mark was making against Alicia. All agencies agreed that the claims against Alicia were false, and Mark was thought to be in mental health crisis himself. A beat officer was assigned to check on Alicia and discuss any risks she faced, and CSC told Alicia to call the police if Mark made any contact with her.

- Mark continued the stalking against Alicia and began to contact Somerset Children's Safeguarding Partnership, via Somerset Direct[28]. Alicia told CSC that she was fed up with the number of allegations being made against her by Mark and that she felt nobody was taking her seriously.

- By mid-May 2020 Mark was posting allegations on Alicia's workplace Facebook page. Mark charged with harassment against Alicia and the case was listed in court for July 2021.

- In June 2020 the mental health team had contact with Alicia via text and phone (COVID19 restrictions were still in place). Alicia appeared well in herself and told the mental health team she had stopped taking her medication, her relationship with Simon was better, he was behaving differently, and was having contact with child 4 and 5. Alicia described feeling very unsettled about Mark's stalking behaviours. A face-to-face appointment was to be arranged when the COVID19 lockdown restrictions were lifted, and Alicia stated her preference was to be discharged from the mental health team.

- In June 2020 Alicia told CSC that she thought someone had been in her garden. Alicia made a further complaint to the police in June 2020 after Mark had doctored images of Alicia to look like child abuse and sent them to her work. The police added this complaint to the investigation.

[28] https://somersetsafeguardingchildren.org.uk/glossary/somerset-direct/

- Two days after her complaint to the police Alicia informed CSC that Mark had been in direct contact with her, Alicia told CSC she had not informed the police about this contact and was instructing a solicitor to support her with the ongoing harassment.

- By July 2020 CSC noted that Mark's calls to them were becoming repetitive and abusive, they temporarily blocked his number. The police informed CSC that they would be interviewing Mark and when they told him he could show the photo's he claimed to have on his phone of Alicia he claimed his phone was broken.

- During July 2020 CSC noted Alicia was struggling to cope. Child 3 was unwell with toothache and would have violent outbursts. Alicia asked for respite for child 3. The school observed that Alicia had bruising to her arms which Alicia said was from child 3, she also told CSC that child 3 had attacked child 5. At an unannounced visit from CSC the SW observed Alicia appearing 'hectic'. Alicia told the SW that she would never hurt her children but wanted to *"go away on her own and put a noose around her neck"*. At a meeting the next day child 3 was observed hitting and pinching Alicia, and Alicia explained that she had been struggling to give child 3 medication for her tooth ache as child 3 didn't like it. Alicia was advised to contact her GP regarding her own mental health, and they discussed Alicia going back on her medication. CSC placed all three children back on the child protection register, and Alicia was accepting of this decision.

- At the strategy meeting for the child protection plan the police noted that Alicia had joked about throwing child 3 out of the window, and that lockdown had considerably reduced the support for Alicia from family, friends, and professionals.

- In July 2020 Alicia contacted the mental health team where they observed she looked 'gaunt and tired'. Alicia described herself as psychotic and said she wasn't sleeping or eating. Professionally there were no signs of psychosis observed, but Alicia did appear 'irritable and exhausted'. Alicia agreed to re-start medication for her mental health.

- Later in July 2020 Alicia contacted the police to complain about the way the stalking Mark is subjecting her too was being handled. She told the police she had lost four stone and felt suicidal. The officer in charge (OIC) of the case contacted Alicia directly and explained the case was being sent to the Crown Prosecution Service (CPS) for a charging decision. Alicia seemed satisfied with this outcome and was encouraged by the OIC to continue engaging with her mental health worker.

- In August 2020 calls were made to CSC from Mark stating he knew where Alicia lived. CSC requested that markers were placed on Alicia's address. During August 2020 CSC liaised with Alicia about further options on going into another refuge and discussed the possibility of getting an NMO against Mark. Alicia informed CSC that she would be going to stay at her father's house in Derbyshire with the children whilst he was on holiday. This plan ultimately fell through because her father was unable to go away. Alicia's Dad later clarified for panel that the plan was for Alicia to move to Derby permanently, but this fell through.

- Alicia fled to a refuge in Hampshire, run by Stop Domestic Abuse, and stayed there for a period of just over a week. No concerns were raised about Alicia whilst she stayed in the refuge with her children (child 3, 4 and 5). The case was heard at MARAC in Portsmouth prior to Alicia returning to Somerset, and this information was shared with CSC in Somerset. The refuge staff also referred Alicia to national stalking services.

- During this time the mental health team did have a discussion with Alicia about the impact Mark's stalking behaviours were having on Alicia's mental health.

- In August 2020 Mark began harassing the social worker's and foster carer's for child 1 and 2. No further action was taken as the victim did not wish to pursue a complaint.

- Alicia contacted the police again in August 2020 to complain about the way the case against Mark was being handled, she again stated she felt suicidal.

- On her return to Somerset, in early September 2020, Alicia was referred to MARAC and to the SIDAS IDVA service. She also spoke to CSC and requested call logs they had of Mark harassing for an NMO. The SW explained that they kept no logs, and Alicia became upset about this, then stated she refused to work with CSC, but she was happy for CSC to contact the children's school and her mental health worker for updates.

- When Alicia spoke to the SIDAS IDVA she told them she had blocked Mark, but feels isolated as she can't use her social media accounts in case, he finds her. During this time Alicia was assigned a new social worker and she resumed contact and support with them for her children.

- In late September 2020 the SIDAS IDVA service were assessing whether to close Alicia's file because there was 'no current abuse'. The IDVA informed CSC that an NMO would be difficult to get as there was no direct contact from Mark to Alicia.

- In October 2020 Mark continued his course of harassment against Alicia by contacting CSC again, this time he claimed Alicia was involved in prostitution and taking drugs. When the social worker visited Alicia all the children seemed happy, and Alicia's house was clean and tidy. After informing Alicia of Mark's continued harassment Alicia became distressed and asked the social worker *"why is he doing this?"*. This information was shared with the police and Alicia said she was scared to leave the house, and sometimes her back gate was open after she knows she had shut it. Alicia explained that the only thing that was stopping her killing herself was the thought of child 3 ending up in a disabled children's home. Alicia was offered safety advice and safeguarding for her and her children. All agencies agreed that Mark's allegations were false. Alicia asked CSC not to inform her of any further allegations made by Mark and to just inform the police.

- Later in October 2020 Alicia made a complaint via the Police and Crime Commissioner (PCC) for Avon and Somerset about the way the case against Mark had been dealt with. This case was sent to professional standards, but the delays appear to be in relation to CPS charging advice rather than police process.

- In mid-October 2020 Mark contacted the social worker via email and said, "*I know where she lives"*. The SIDAS service received this information with a high-risk DASH score. The IDVA spoke to Alicia, and she told them about the complaint to the PCC, she also said she wasn't sleeping but reluctant to take any medication as she needs to "*stay vigilant"*. The IDVA told Alicia to keep them up to date with the police investigation.

- In mid-November SIDAS spoke to Alicia and explained they were closing the case as there was no role for them due to there being no DVA. Alicia accepted this and said she was doing better Alicia told SIDAS she was feeling strong and wanted to start her own business, although her dad later clarified for panel that she had to resign from her job because of the harassment Mark was subjecting her too. A day later Alicia was also discharged from the mental health team after a home visit. Alicia said she felt stable again and agreed that she didn't meet the threshold for mental health intervention at that time but would contact her GP and the mental health team in the future if she needed support.

- In December 2020 Alicia spoke with her social worker who said Mark wanted to give child 3 a Christmas present. Alicia refused and said she thought Mark had been knocking her door at 00:45. The social worker observed that Alicia seemed to be engaging well with agencies at this time. CSC noted that Mark continued to contact them during Christmas about the present he wanted to give child 3.

- In January 2021 the UK was in a second lockdown period and the school noted the attendance for child 3 was intermittent. CSC observed Alicia was struggling with the care of the children, although she did say she had some support from family and friends.

- In March 2021 Mark contacted CSC and claimed that Alicia was in a relationship with a drug addict. The social worker wanted to explore these allegations so spoke to Alicia who explained that the man Mark claimed she was having a relationship with was dating her friend and they had agreed to let Mark see child 3 at Alicia's house without her knowledge, so Alicia ended the friendship immediately. Alicia stated that she was not in a relationship with anyone, and the social worker noted that Alicia was her usual talkative self, and whilst she sometimes went off topic in the conversation that it was not a cause for concern.

- In March 2021 Mark made two reports against Alicia in successive days to the police. The first allegation was that Alicia was threatening Mark and his girlfriend, the second was that Alicia was using heroin and other drugs. No action was taken by the police against Alicia and all information was shared with CSC, health, education, and the IDVA service.

- Later in March 2021 Mark began to email the Chief Constable of Avon and Somerset Constabulary complaining about the case against him. Mark also requested the police undertake a welfare check on child 3 stating a drug user was living with Alicia.

- Mark continued to contact the Chief Constable claiming that child 3 was at risk. The officer investigating described Mark's contacts as the *"ramblings of a madman"*.

- In April 2021 SIDAS received another referral from the police due to the ongoing stalking and harassment Mark was subjecting Alicia too. SIDAS contacted Alicia, but she said they couldn't help her and she was unhappy with the lack of support from all agencies including the police. Alicia stated, *'when she is found dead we will all be made accountable'*. Alicia declined to do a DASH and rejected the offer of civil injunctions stating she couldn't afford it. The SIDAS worker recommended the case be heard at MARAC due to concerns for ongoing stalking and harassment.

- In April and May 2021 the attendance for child 3 drops off at school. There are a number of contacts with CSC and Alicia due to child 3's issues, including that child 3 is attacking Alicia, which Alicia explains is due to the fact that child 3 finds it hard to communicate because of her autism. On one occasion Alicia calls the police and on attendance they observe that things in the house are calm, but Alicia has bruises on her. The police inform CSC of their concerns that Alicia is finding it hard to cope with child 3 and CSC offer support.

- Later in May 2021 the police and CSC observe a break down in Alicia's mental health presentation. Alicia had informed the police that she was concerned the children had been sexually abused whilst being left with a family member when she was at the refuge in August. When the police visited her at home Alicia was concerned there was someone in her attic and she was worried there were sexual comments in one of the children's books she had. The police assessed that there were no substance to the comments and were concerned about Alicia's paranoia, and by the time they left she was much calmer. CSC and the health visitor were visiting the family the next day and the police passed the information onto CSC.

- In May 2021 there is a log on the police system in relation to Mark's deteriorating mental health and drug taking. He was encouraged to seek help from the mental health team.

- Alicia continues to reiterate her concerns about sexual abuse of her children and contacts both the mental health team and her GP. CSC made contact with Alicia and noted that some of her comments regarding her concerns did not sound logical or rational. CSC noted it was good that Alicia was recognising she needed to engage with her GP and the mental health team.

- After liaison with the health visitor who also had concerns for Alicia's mental health the social worker visited Alicia at home. The social worker observed Alicia's presentation escalating whilst she was there and that she was *'paranoid, erratic,*

angry, tearful, and emotionally unstable'. On this visit Alicia asked for the children to go into respite care for a few days so she could have a rest. This was organised by the social worker and child 3 went to a separate foster carer to child 4 and 5, and all three children remained open under s.17 of the Children's Act 1989[29], as children in need.

- By the end of May Alicia had child 4 and 5 back in her care and was in contact with the mental health team. Child 3 was returned to Alicia's care a few days later.

- In June 2021 CSC received a call from the care agency Medgen[30], who were commissioned by CSC to provide support to the family. They had concerns for Alicia's behaviour as she appeared distressed and angry, and they observed her smoking what appeared to be cannabis. Alicia and the children went to stay with her brother in Portsmouth.

- Contacts between CSC and Alicia were recorded whilst she was in Portsmouth, and she stated she didn't want to return to Somerset.

- In June 2021 Alicia's brother called the Hampshire Safeguarding Emergency Duty Team (EDT). He expressed concerns for Alicia's mental health as she appears to be hearing voices and thought the police were listening to her through the Wi-Fi. He also expressed his worry that Alicia wasn't coping with the care of the children. EDT advised him to contact 111 regarding Alicia's mental health but he was reluctant to do this. EDT Hampshire shared this information with Somerset CSC.

- Somerset EDT were unable to contact Alicia and on further conversation with Hampshire they were informed that Alicia had asked Simon to pick the family up and bring them back to Somerset. On return to Somerset an agency worker for Somerset EDT visited Alicia but she asked them to leave the property. The worker stayed in his car nearby as he was concerned for Alicia's welfare as she felt the police were watching her and they noted that she was *'on edge'*.

- Later that day a call from a member of the public to the police was made. On arrival the police noted the scene at the house was *'chaotic'*. The children were unsupervised and outside of the house, they were all hungry and dirty. Alicia stated everything in the world was fake and compared her life to the Truman show. Alicia was detained on a s.136 order under the Mental Health Act[31] and taken to hospital. The children were placed in foster care.

- Whilst in the hospital the psychiatric team undertook a mental health act assessment and noted that Alicia was suffering an emotional crisis due to social stressors, stating she was unable to cope and feeling overwhelmed. The psychiatric team assessed Alicia's presentation to the police as being brief transitory psychotic symptoms or behavioural due to emotional stress. Alicia was diagnosed with Emotionally Unstable

[29] https://www.legislation.gov.uk/ukpga/1989/41/section/17
[30] https://www.medgen.co.uk/?source=google.com
[31] https://www.legislation.gov.uk/ukpga/1983/20/section/136

Personality Disorder and the psychiatrist felt Alicia's presentation was representative of this diagnosis.

- CSC visited Alicia on the ward, and she consented to child 3 remaining in foster care. CSC informed Alicia that child 4 and 5 were now with Simon as he had parental responsibility. Alicia was unhappy about this and said she needed to leave the ward to get them back as Simon would never give them back now.

- CSC convened a meeting to issue proceedings regarding the care of Alicia's children as it was felt she could not care for them. CSC requested interim supervision orders for child 4 and 5 to remain in the care of Simon and for child 3 to remain in the care of the local authority. Alicia was unaware of the proceedings.

- Five days after being sectioned Alicia discharged herself from the hospital but returned on the same day. A day later a note was added by the night staff at the hospital stating as Alicia was expressing suicidal thoughts, she stated: *"I am not suicidal but I am fucked off."*

- Six days after being sectioned Alicia was discharged from the hospital and it was noted that she was being disruptive on the ward. The hospital staff felt that Alicia was not detainable as she did not meet the threshold for a mental health problem. Alicia said she would tell the police she was suicidal but the staff at the hospital did not believe this to be the case.

- Seven days after being sectioned, and a day after being released Alicia called CSC to check on the welfare of the children. On the same day neighbour reported a public order offence to the police when Alicia shouted at her and the neighbours' children in the street, the neighbour said she did not want any further action taken but wanted Alicia to get help for her mental health.

- Two days after this incident and ten days after being sectioned Alicia completed apparent suicide by hanging. May she rest in peace.

13. Overview

This section gives an overview summarising the information known to agencies and professionals. The IMR information from eight separate agencies are detailed below, grouped into service area (e.g., health, voluntary sector, criminal justice etc), where appropriate. Each agency drew on learning from incidents, contacts, or general engagement, with either Alicia, Mark, or Simon. Where appropriate some pertinent information is shared by agencies outside the timeline period to add context to the review. Full analysis by the panel and review author/chair are detailed in section 14.

Criminal Justice

13.1 Avon and Somerset Constabulary (A&SC):

Between January 2016 and June 2021, A&SC had contact with Alicia on 56 separate occasions, these included incidents that related to Mark and Simon. The majority of interactions were in relation to domestic abuse. At the time of her death Alicia was being harassed and stalked by Mark, but her relationship with Simon appeared to be more settled.

Records evidence:

- Simon had Police National Computer (PNC) records from 2004 to 2020 for 3 convictions (3 offences). 2 offences related to police/courts/prisons and 1 offence relating to drugs.
- Mark had PNC records from between 2003 and 2021 for 7 convictions (16 offences) as follows:

  7 Offences against the person (2011 - 2015)

  3 Offences against property (2011)

  2 Theft and Kindred offences (2003 - 2011)

  4 Offences relating to police/courts/prisons (2004 - 2015)

- Mark was successfully prosecuted for harassment of Alicia after her death

A&SC noted the struggles Alicia had with her mental health and the long-term abuse she was subjected to from Mark and Simon. She frequently called the police but was sometimes reluctant to engage in criminal justice options after the initial contact. Alicia did not want to complete DASH forms on occasion, and these were processed on officer's observations.

Alicia was frustrated with the length of time it took for the stalking and harassment case against Mark to be prosecuted, and the police note the delays in the wider criminal justice system having an impact on victims. When Alicia complained about this to the police it was dealt with robustly following the appropriate policies and procedures and Alicia told the police she was happy with the outcome of the complaint. On a number of occasions A&SC tried to expediate the case with the Crown Prosecution Service (CPS), and in August 2020 they highlighted the escalation of the stalking behaviours towards Alicia, but the CPS informed A&SC that the case did not fall into the category threshold to be fast-tracked.

In addition to this the Crown prosecution service dropped the (August 2017) case against Simon due to "lack of evidence" because Alicia did not attend court. Having reviewed the amount of evidence on the file the IMR author noted that it is hard to reconcile the CPS decision.

Referrals to outside agencies, including the IDVA service were processed correctly and there is evidence to suggest that the police tried several ways to engage Alicia in longer-

term support. However, there is no record of engagement with drug and alcohol services and the IMR author notes this could have hampered Alicia's ability to engage in support.

There was evidence of periods of good multi-agency engagement with the police, specifically regarding child safeguarding. The police did note that latter conversations on child safeguarding when Alicia's mental health was declining failed to incorporate discussions on Simon being absent from the children's lives at that time. The IMR author noted that Simon's parenting responsibilities and duty to support Alicia when she was struggling (as long as it was safe to do so) were not addressed – this resulted in all the attention being placed on Alicia and her inability to safeguard the children.

Learning points:

Although there were no specific learning points raised by A&SC as all policies and procedures had been adhered to, the review author notes that it when Alicia did engage in the CJS system she experienced delays and inconsistencies in receiving justice.

Mark began a campaign of stalking against Alicia in March 2020; the initial harassment was vexatious with Mark contacting the police and social services making serious allegations against Alicia. Multi-agency strategy meetings concluded that all allegations were false, and by April 2020 Alicia contacted the police herself and the IMR author noted that she:

> *[Alicia] provides good evidence of the harassment; her ex [Mark] has posted about her on her employer's recruitment page on Facebook. Investigation progressed well – the Author has read a total 119 logs on this Niche record, resulting in the arrest and charge of [Mark].*

However, during the period between the arrest of Mark in April 2020 up until her death in June 2021 he continued his campaign of stalking against Alicia. Alicia was left to pursue civil remedies on her own to try and protect herself from Mark's stalking, and A&SC did not utilise the use of a Stalking Protection Order, with only one record in the A&SC chronology and IMR stating they gave Mark 'words of advice' in May 2020. The Home Office Quality Assurance panel noted this should be highlighted as poor practice. This alongside the significant delays with the CPS case will be discussed further in analysis section 14.1. With recommendations being offered by the panel in section 16.

Good Practice:

Operation Ruby officers were used in this case as they are specialist child protection officers and have enhanced knowledge and skills as detectives. When Alicia liaised with local safeguarding Unit, Lighthouse, the same Victim and Witness Care officer spoke to

her when they were available which offered a continuity of care, and Alicia said she benefitted from this and appreciated the support.

Health Services

13.2 Public Health Nursing (PHN) (Health Visitor):

The Public Health Nursing service has provided the family with a Universal Partnership Plus service as defined by the Healthy Child Programme. Over the course of involvement, the family had 6 named Health Visitors. The children received all of their mandated core contacts and additional developmental reviews where required. Appropriate referrals were made to additional services. The health visiting service provided a total of 93 contacts either by telephone, home visits or by the family attending clinic. For a period of time during the review period the UK was in lockdown due to the COVID19 pandemic.

The IMR reveals consistent support to Alicia with regards to the care of her children and the domestic abuse and stalking she was being subjected to from Simon and Mark respectively. It is of note that the partnership working between PHN and other professionals, including children's social care over the four years they were involved with Simon and Alicia resulted in a much calmer environment for the whole family. From July 2019 until March 2020 there was a period of stability for Alicia and her children and there were no further reports of domestic abuse from Simon, he had moved out of area but had contact with the children. However, the campaign of stalking initiated by Mark in March 2020 had a significant impact on Alicia and the HV noticed the steady decline in her presentation and mental health.

There was evidence of good multi-agency working with the police and referrals were made to external agencies, including domestic abuse and mental health services. However, the HV team referred Alicia to MARAC on three occasions and two of these were rejected due to 'not meeting the threshold'. In addition, PHN referred Alicia for a mental health assessment in May 2021, this was just after her children had gone into temporary care for respite and Alicia said she felt she had suffered a mental breakdown. Unfortunately, no assessment was undertaken as the mental health team stated her behaviour was due to the stress related concerns that her children had been sexually abused. The IMR author records concerns that the assessment did not take place as the mental health team knew Alicia and it may have helped in a time of crisis, this was also a month before Alicia's death.

PHN noticed how the pandemic adversely impacted on Alicia's ability to cope, although she was parenting to the best of her ability, they note Alicia had a child with autism (child 3) and two children of pre-school age (child 4 and 5), in addition she was being subjected to stalking from Mark.

<u>Learning Points:</u>

Towards the end of Alicia's life, she was in mental health crisis and PHN noted the link between Alicia's own experience of Adverse Childhood Experiences (ACES) and the diagnosis of borderline personality disorder (BPD). They recommend a pathway of support in Somerset be implemented if one does not already exist. In addition to this PHN recognise the importance of trauma informed practice particularly in relation to ACEs and intergenerational repetition for children.

Good Practice:

PHN incorporated conversations about domestic abuse and the impact on her children regularly and made appropriate referrals to agencies. Where referrals were rejected health visitors challenged these and these decisions and continued to share their concerns about the risk to Alicia and her children in order to safeguard the family.

Alicia did have short periods of disengagement with the health visiting team and during these times PHN continued to attend safeguarding meetings in relation to the family.

The review author noted that generally Alicia had a good trusting relationship with her health visitors, and she clearly benefited from their support during periods of significant stress in her life.

13.3 Somerset Integrated Care Board (ICB):

Prior to July 2022 and when Alicia was alive the ICB was incorporated within the Somerset Clinical Commissioning Group (CCG). Within the review timeline period, Alicia had contact with her GP surgery on 91 separate occasions. There were approximately 58 telephone GP conversations, 9 face to face GP consultations and 24 clinical consultations (Non-GP). Most of the GP consultations were related to medication reviewing for anxiety and depressive thoughts.

Records show that she engaged with the GP practice well and they were aware of her mental health issues and the domestic abuse and subsequent stalking she was being subjected too. The IMR author also notes the impact losing child 1 and 2 into local authority care had on Alicia. Later in life Alicia understandably struggled to cope when caring for 3 young children, one of whom had autism, and this combined with significant DA and stalking she was being subjected to placed a lot of stress on her.

The IMR author notes that Alicia loved her children very much and she tried very hard to protect them. She was very anxious about being separated from them which exacerbated her distress when she was finding it hard to cope.

Learning Points:

The IMR author notes on two occasions there could have been more professional curiosity from the practice. In September 2017 Alicia presented to the GP surgery with bruising to her lower legs and abdomen and this was thought to have been caused by specific medication Alicia was taking. However, the was no further exploration by the GP to assess whether the bruising could have been a result of an abusive incident.

In addition, in May 2020 the GP practice witnessed bruising on Alicia's arms, which she said had been caused by child 3 (because of her autism). Although there is nothing to suggest that this wasn't the case, and other agencies corroborate the behavioural issues child 3 had, including witnessing incidents, the GP did not interrogate this matter further with Alicia, and given the history of DA it would have been appropriate to do so.

Good Practice:

The interactions Alicia had with her GP were overall very positive and the review author noted from both the chronology and the IMR data that she clearly trusted her GP. Generally, the conversations regarding domestic abuse, mental health and referrals to specialist services was very good, and the record keeping by the GP practice was excellent. There is also evidence of good multi-agency working between the GP and other services, including CSC, mental health teams, and the health visiting team.

13.4 Somerset NHS Foundation Trust:

SFT recorded a total of 52 contacts with Somerset NHS Foundation Trust (SFT) during the review timeline period. In relation to safeguarding concerns and possible links to domestic abuse Alica presented to both the Minor Injuries Unit (MIU) and her dental surgery, but the majority of Alicia's engagements were with mental health services.

The mental health teams Alicia engaged with over the review timeline period included:

- Peri-natal Mental Health
- Home Treatment Team
- Psychiatric Inpatient Unit
- Mental Health Inpatient & Urgent Care

Alicia had a diagnosis of Borderline Personality Disorder/Emotionally Unstable Personality Disorder (EUPD) and struggled with rapid mood changes. There are also extensive reports of DA and stalking throughout Alicia's interactions with SFT staff.

The interagency information sharing between SFT departments and multi-agency partners is noted to be thorough and SFT attended six MARAC meetings where the risk towards Alicia was discussed.

At points Alicia struggled to engage with the Community Mental Health Team (CMHT). Between August 2016 and March 2017, Alicia was offered five appointments with the CMHT, two of these appointments were cancelled by Alicia and three were declined. During this time Alicia gave birth to child 4, and the IMR author notes that it may not have been the right time for her to engage in services.

Learning Points:

On attendance at the MIU no DASH was undertaken, despite Alicia disclosing that her injuries were caused by Simon. In addition, the dental surgery referred their concerns to

SFT safeguarding service after they noted bruising to Alicia's arms and face, again a DASH risk assessment was not completed by professionals on this occasion.

The IMR author noted generally that the safeguarding of Alicia's children may have sometimes overshadowed Alicia's own needs. In addition, although Alicia's inpatient stay in the mental health unit provided a stable environment, it did not appear to provide the hoped for benefits. Alicia's diagnosis of EUPD was apparent in her presentation and she was either calm and settled or vocal and antagonistic with staff.

The IMR author succinctly explains:

> *During her inpatient stay, focus primarily was given to presentation and diagnosis rather than a more holistic approach that would have incorporated the wider contextual social issues. It was highly probable at that time that the coexisting stressors of domestic abuse, child safeguarding, child behavioural issues/disability, and processing allegations of her children having been abused, were all potential impacting factors regarding her presentation and inability to cope at that point. It appears that [Alicia's] diagnosis of EUPD (and the inherent safeguarding children concerns) possibly overshadowed the potential for additional factors / options to be explored (potential confirmation bias), for example via liaison with other services, which could have informed a more succinct care plan/risk assessment /discharge plan.*

<u>Good Practice:</u>

The attempts to engage Alicia, particularly in relation to her mental health were consistent, using various means and options to offer her support. When Alicia did feel able to engage there were 40 recorded contacts over the review timeline period. Ranging from both face-to-face support, telephone contact, and home visits. This included exemplary engagement during the COVID19 pandemic.

Liaison and information sharing with multi-agency partners was extensive, and conversations about the domestic abuse and stalking Alicia was being subjected to were approached with compassion and curiosity.

Social Services

13.5 Children's Social Care and Children with Disabilities Team:

CSC had 19 contacts with Alicia from the period of April 2006 until July 2019 that related directly to domestic abuse. From July 2019 until her death there were no further contacts with Alicia in relation to domestic abuse, but Mark continued to use CSC in his stalking campaign of Alicia and made a total of 14 contacts to them from July 2019 until June 2021. The volume of the calls Mark was making and the abusive nature of them resulted in Somerset Council blocking his number for a period of time. In addition, CSC records show a further 8 recorded harassment contacts to either Alicia directly or external agencies from Mark. When social care shared the details of Mark's contact to them with

Alicia, this caused her significant distress, and it was noted that her mental health began to deteriorate during that time.

In March 2020 CSC close the file for Alicia's children as they had no further concerns in relation to her parenting. Until her death Alicia remained open to the Children with Disability Team to support her with the care of child 3.

Learning Points:

The COVID19 pandemic impacted on social workers visiting patterns, agency support staff, and on school closures, and this had an adverse effect on many families.

The IMR author did not offer any recommendations, but the review author noted through the chronology and IMR data that professionals from all agencies lacked a general understanding of the significant impact Mark's stalking behaviour had on Alicia. In addition, the risk factors and types of stalking Mark exhibited used multi-agency partners to punish and scare Alicia, this included social care. Further analysis on this will be offered in sections 14.1 and 14.4, and recommendations will follow in section 16.

Good Practice:

It is clear that engagement with social care was a significant feature in Alicia's life. Sometimes Alicia engaged well with the support and sometimes this wasn't easy for her to do. But social care kept good overall engagement with the family over the review timeline period.

Discussions relating to domestic abuse were handled well and included both Simon and Alicia. Multi-agency information sharing was good, especially with A&SC, the mental health team, and the GP practice.

Domestic Abuse Services

13.6 Somerset Integrated Domestic Abuse Service (SIDAS) Livewest:

Within the review timeline period dating January 2016 to April 2020, Livewest[32] held the contract for the SIDAS service. During that time, they received information about Alicia and engaged her intermittently in services from January 2016 to August 2019. Collectively there were five referrals for Alicia and all contacts were in relation to the domestic abuse she was being subjected to from Simon, apart from one contact where Simon was listed as the victim and Alicia the perpetrator which the Livewest SIDAS team correctly challenged.

There were five MARAC meetings where the case was listed, but some MARAC referrals made to the SIDAS Hub team were rejected. The documentation on why the risk posed to Alicia from Simon did not reach the threshold was sparse. The SIDAS team and

[32] https://www.livewest.co.uk/

community health colleagues in the queried and challenged the MARAC rejections, which will be discussed further in section 14.2.

Learning Points:

The IMR author notes that the rejected MARAC referrals could have provided an opportunity for multi-agency partners to review the number of referrals coming through in relation to Alicia. In addition, the records show that Alicia's fear of having any more children removed from her care acted as a barrier to her seeking support. The IMR author notes this could have been a good opportunity for the IDVA to feed into the Child in Need (CIN) process rather than rely solely on contact with the health visiting team.

The review author notes that despite SIDAS Livewest challenging the decision to list Alicia as the perpetrator against Simon in July 2018, the subsequent records from SIDAS Livewest for MARAC referrals from other agencies in March and July 2019 re-affirm the previous position with Alicia as a perpetrator, and or their relationship being 'volatile' - with staff being told not to do home visits because of this.

There are no recommendations offered by SIDAS Livewest as they do not hold the contract anymore. However, the review author notes the IMR is written in a way that insinuates victim blaming of Alicia's inability to engage with domestic abuse support. This does not reflect the work undertaken by the direct frontline team at SIDAS Livewest and will be fed back to the IMR author on publication of the review.

In addition, there appears to be very little recognition of Alicia's mental health difficulties and liaison with mental health services from the Livewest SIDAS team, this is particularly pertinent in relation to victims' risk of apparent suicide and the links to domestic abuse, which will be discussed further in section 14.4.

Good Practice:

The IMR author did not record any observations of good practice, however the review author noted the good interagency working with the health visiting team and the appropriate challenge of MARAC rejections. On a number of occasions the case was reviewed by a service manager and kept open to the team as they were concerned about the patterns of abuse and did not agree with the decision to not list at MARAC. In addition, the Livewest team queried the referrals where Simon was listed as a victim of Alicia. This latter point was raised well by the staff at Livewest and they correctly linked up the previous reports of DA where Simon was the primary perpetrator and identified the fear Alicia expressed about Simon, as well as noting she had taken out a non-molestation order against him, which he breached within 1 hour. As a result they undertook a further contacts with Alicia and she disclosed being scared that she had assaulted Simon when he was being abusive.

13.7 SIDAS The You Trust:

The SIDAS contract transferred to The You Trust[33] in April 2020. The You Trust SIDAS service had three referrals for Alicia within the review timeline period which resulted in six contacts via the IDVA service over a three-month period between September 2020 to November 2020. All contacts relate to the stalking she was being subjected too from Mark.

Learning Points:

The IMR author notes there were some discrepancies in the uploading of internal forms from the IDVA on occasions. In addition, Alicia's mental health needs do not appear to have been explored in enough detail. On the initial assessment Alicia indicated suicidal ideation and feelings of being isolated, she also expressed significant fear that Mark would kill her. In a referral from the LSU in October 2020 Alicia expressed feeling *'terrified and suicidal'*.

The IMR author correctly observes that the stalking Mark was subjecting Alicia to was not explored in detail and referrals were not made to specialist services. In addition, the IMR author notes that the option of a Stalking Protection Order were not identified, and Alicia was given advice about other civil remedies she could pursue herself.

The delay the last incident reported to SIDAS, and the final MARAC meeting was highlighted as a lengthy gap and the MARAC provided very few actions for the IDVA to undertake. The review author notes that it appears the MARAC did not identify the case as one of domestic abuse, but missed the opportunity to commit to actions that addressed the significant patterns of stalking and harassment Alicia was being subjected to from her ex-partner Mark.

Good Practice:

The records show very timely responses from The You Trust SIDAS service. On initial referral from Stop Domestic Abuse the contact was made on the same day. Attempts to contact and engage Alicia remained consistent and this was particularly noticeable on the final referral The You Trust received. By that time, it is obvious that Alicia had endured a sustained campaign of stalking from Mark, and she was frustrated by the lack of action being taken in the case. Alicia spoke to the service in April 2021, two months prior to her death and the records state:

[33] https://theyoutrust.org.uk/

> [Alicia] reported to be very upset with the lack of support she has been receiving from Police and all other agencies and commented when she is found dead then we will be made accountable.
>
> SPOC1 advised [Alicia] that IDVA1 had supported in the past and could offer further support. [Alicia] got very agitated and said that we cannot help her, and nothing is available.

Although Alicia expressed her justified frustrations with the SIDAS Single Point of Contact (SPOC) service, and declined support, the SPOC team offered her a number of options.

The records show that the team also engaged well with multi-agency partners, and they highlighted the need for CSC to share intelligence with the police on the contacts Mark was making to them.

13.8 Stop Domestic Abuse (SDA):

Stop Domestic Abuse provided Alicia and her children with refuge space in Hampshire for a period between August and September 2020. The refuge provision offered was due to Alicia fleeing Somerset in fear of the stalking she was being subjected to by Mark.

Learning Points:

The IMR data is very limited from Stop Domestic Abuse and they highlight no learning points. However, the review author notes there was no record of stalking support or referrals to specialist stalking services for Alicia when she left the refuge.

Good Practice:

On leaving the refuge SDA actioned all appropriate referrals for Alicia and her children in relation to safeguarding and referred to MARAC and the You Trust SIDAS service in Somerset.

14. Analysis

The benefit of hindsight enables the Chair and the panel to assess where different decisions or actions could have been a catalyst for support and or intervention for Alicia. This analysis is based on information provided in the IMRs and, perhaps more importantly, Alicia's family provided a focus for the panel to understand a more holistic perspective of the situation. The panel additionally noted the high calibre of the IMRs from all agencies and were grateful for the input from authors as it enabled robust analysis.

This section gives an overview summarising the information known to agencies and professionals involved with Alicia, Mark and Simon, as well as any other relevant facts or information to assist the review.

14.1 Coercive Control and Stalking

Relevant TOR points:

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

Coercive control legislation came into effect in the UK on the 29th of December 2015 and was therefore in force as a crime when Alicia was in a relationship with both Mark and Simon respectively. To understand domestic abuse holistically we must understand that coercive and controlling behaviour acts as the backdrop to physical and or sexual violence[34].

The cross-Government definition of domestic violence and abuse outlines controlling, or coercive behaviour as follows:

- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

- Controlling or coercive behaviour does not only happen in the home; the victim can be monitored by phone or social media from a distance and can be made to fear violence on at least two occasions or adapt their everyday behaviour as a result of serious alarm or distress.[35]

[34] https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf
[35] Controlling or Coercive behaviour in an intimate or family relationship – Statutory Guidance Framework – Home Office December 2015 p. 3-4
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

It is clear Alicia experienced CCB from both Simon and Mark, but the focus of the CCB analysis for this review will be contained to her relationship with Simon. Further analysis on the correlation of CCB and stalking in relation to Mark will be discussed below.

Alicia described Simon as being jealous and controlling, and she also disclosed Simon calling her a *whore* and a *skank* at the incident in August 2017. The child protection plan in December 2017 records Simon as being *'very violent and controlling.'* There were numerous reports of Simon perpetrating physical violence towards Alicia, including non-fatal strangulation, smashing Alicia's head against a door frame, and dragging her by her hair. Alongside these incidents the other behaviours Simon exerted are set in the context of power and control. Alicia described Simon either refusing to leave her property when she asked him to, on one occasion laughing at her when she suggested it or frequently turning up unannounced. Simon would smash up her property, and he stole her phone. The message this sends to victims is designed to instil fear and isolate their victims. Simon was reported to shout through Alicia's letter box, and smash her door in. The exertion of violence on inanimate objects should not be dismissed as a lesser incident – the message it sends is clear 'I could do this to you too.' In addition, we know that there were several reports to the police from third parties including professionals where they witnessed Simon shouting through the letter box, loud arguments, or smashing up her property. This meant Alicia was placed in the frame of not protecting her children because of Simon's behaviour and her fear of outside agency interference knowing about the abuse could have resulted in her trying to keep Simon happy or remaining compliant so as not to alert the authorities to the DA she was experiencing.

We also know that both Simon and Alicia would use drugs and alcohol, although both received help for this later in the review timeline period and appeared to reduce their substance use, it is important to note that this can compound issues of violence and control. Research shows[36] that perpetrators can use alcohol and substance use to their advantage, using it as a means of dependence and isolating them from accessing options of support.

Given that Alicia had lost her two oldest children into local authority care, we know from the interactions she had with Livewest that this prevented her from disclosing the levels of abuse she was being subjected to. Having two relationships in succession with Mark and Simon that were abusive, and then Mark re-entering her life to initiate a campaign of stalking against her, meant the last years of Alicia's life was marred with abuse from the men she trusted. This context is important to reflect upon from agencies when they are offering support, because years of coercive and controlling behaviour then subsequent stalking would have significantly impacted her mental health.

Stalking

There is a through line from the behaviours of coercive control to stalking. The actions often follow the same patterns, but the difference is that the stalker has become

[36] https://bristoluniversitypressdigital.com/view/journals/jgbv/8/2/article-p215.xml

obsessed and fixated with his victim. The College of Policing guide[37] officers to remember the mnemonic **FOUR** to identify whether a case is stalking or harassment:

- **Fixated**
- **Obsessed**
- **Unwanted**
- **Repeated**

The Suzy Lamplugh Trust definition[38] of Stalking is:

> "a pattern of **fixated** and **obsessive** behaviour which is **repeated**, **persistent**, i**ntrusive** and causes fear of violence or engenders alarm and distress in the victim".

There is a universal acceptance that stalking behaviours include obsession and fixation, and that the behaviours are repeated and unwanted. Mark began his stalking of Alicia eight years after they had separated, and although there is no data to indicate what initiated his stalking after such a long period of time it is important to analyse the typologies of stalkers.

It is not easy to categorise stalkers and they do not easily fit into any one type, but clinical experts[39] have offered descriptions and motivations for some stalkers. The Rejected Stalker is the most common type of stalker, they are also the most dangerous and most likely to be violent. Mark would readily fit into this category:

> **The Rejected Stalker**[40] is a type of stalking that occurs when a close relationship has broken down. Typically, the victim is a former sexual partner, but family members, close friends, or others with a strong emotional connection to the stalker can also be targeted. The initial motivation of the Rejected stalker is usually one of two things: either attempting to reconcile the relationship or seeking revenge for a perceived rejection. In some cases, the stalker may have mixed feelings about the victim, vacillating between wanting to restore the relationship and wanting to inflict harm. For some, the stalking behavior may serve as a substitute for the past relationship, allowing the stalker to maintain a sense of closeness with the victim. For others, the behavior may serve to boost their damaged self-esteem and improve their self-image.

In addition, Mark could arguably be assessed as engaging in one of the other five typologies, namely Resentful Stalker:

---

[37] https://library.college.police.uk/docs/college-of-policing/Stalking-and-Harassment-2020.pdf
[38] https://www.suzylamplugh.org/news/press-release-national-stalking-awareness-week-2024#:~:text=Stalking%20is%20defined%20by%20Suzy,and%20distress%20in%20the%20victim.
[39] https://www.stalkingriskprofile.com/about
[40] https://www.stalkingriskprofile.com/what-is-stalking/types-of-stalking

The Resentful Stalker[41] engages in stalking behavior due to perceived mistreatment or injustice and seeks revenge or to "even the score" with the victim. This type of stalking typically targets strangers or acquaintances who the stalker believes has wronged them. In some cases, severe mental illness can contribute to paranoid beliefs about the victim, leading to stalking behavior as a way to "get back" at the perceived perpetrator. The stalker derives a sense of power and control from inducing fear in the victim and may justify their behavior as a means of fighting back against oppression.

Stalking became a criminal offence in England and Wales in May 2012, and this was well within the review timeline period. The legislation[42] points to evidence of a course of conduct and must comprise of two or more occasions alongside causing the victim alarm or distress which has a significant adverse effect on their usual day to day activities. From the data analysed we know that Mark continued to stalk Alicia from March 2020 until her death in June 2021 (1 year and 3 months), we also know that this had a significant impact on her life, including the fact she fled to a refuge with her children to stay safe. But the significant delays in CPS processing the case meant that Alicia was left feeling frustrated and let down by the criminal justice system, and although Mark was eventually convicted, Alicia was not alive to see justice being served as a victim of Mark's prolific stalking of her.

Although Alicia directed her frustration at A&SC they had already submitted the file to the CPS and were unable to have control over the CPS timescales, they did chase the CPS for Alicia in both July 2020 and October 2020 and the logs read:

July 2020 log

"currently we are experiencing a high volume of requests and this is impacting on timeliness. Discussions are being held with senior managers in the Police and CPS about this".

October 2020 log

"The case has been with CPS for a long time; therefore, [Alicia's] frustration is recognised. However, this is a matter for CPS not police."

This was after a period of lockdown in the UK and the pandemic had a significant effect on delays in the CJS which continue to the time of writing in 2024. The impact COVID19 had on victims will be discussed further in section 14.5. But it is also important to recognise that a recent report[43] commissioned by the London Victim's Commissioner, Claire Waxman, identified consistent failures in the CJS for victims of stalking today.

[41] https://www.stalkingriskprofile.com/what-is-stalking/types-of-stalking
[42] https://www.cps.gov.uk/legal-guidance/stalking-or-harassment
[43] https://victimscommissioner.org.uk/news/statement-london-stalking-review-2024/

Although Alicia's experience was in 2021, evidence in 2024 reveals confusion from the Metropolitan Police and wider CJS in anti-stalking laws.

There are other legislative tools to keep victims safe which do not appear to have been considered by A&SC, namely a Stalking Protection Order (SPO). An SPO is a civil order applied for by the police and free of charge to the victim. It is unlikely that Alicia would have known about SPOs herself and the fact that no agency pursued this as an option to keep her safe was a missed opportunity by all.

When Mark continued to harass and stalk Alicia and she complained to the police in April 2020 officers visited Mark and gave him 'words of advice' which is against College of Policing guidance[44], although it should be noted that this guidance came only a few months prior to A&SC taking this action. Instead of an SPO Alicia was told to get a non-molestation order (NMO), which meant the onus was solely on her to pursue protection and she subsequently told agencies she could not afford this option, which may have been due to the fact she worked and was struggling to get legal aid. The review author requested clarification from A&SC as to why an SPO was not explored and the panel member explained that at the time it was seen as a duplication of the non-molestation order, but an NMO does not provide the same level of protection as an SPO, the latter of which has the option of specific positive requirements that the offender is ordered to carry out. Of note the aforementioned Waxman report[45] identified continued concerns on the low number of SPOs being issued in comparison to the number of stalking offences.

Alicia's experience of repeated behaviours even after the arrest of Mark and the failure to apply for an SPO is consistent with other victims. In 2022 The Suzy Lamplugh Trust lodged a super complaint[46] against the police highlighting the insufficient use of SPOs nationally, and the repeated breaching of orders (or words of advice in Mark's case) leaving victims unprotected and offenders undeterred.

Psychologist and leading expert in stalking, Lorraine Sheridan[47], explains that stalking is really about the motivation for the behaviour rather than the behaviour itself. In many cases, it involves the targeted repetition of otherwise ordinary or routine acts. What those behaviours look like can be expansive and ever creative; they include following a victim, monitoring via the internet, or other electronic communications, use of spyware, CCTV, tracking devices, interfering with property, and loitering outside public and private spaces.

---

[44] https://library.college.police.uk/docs/appref/Advice-supervisors-managers-senior-leaders-stalking-harassment-offences.pdf

[45] https://victimscommissioner.org.uk/news/statement-london-stalking-review-2024/

[46] https://www.suzylamplugh.org/Handlers/Download.ashx?IDMF=cf3fdc8b-f958-4cc0-9fc7-9ce6de3e9137

[47] Weller, M., Hope, L. and Sheridan, L. (2014) *Police and Public Perceptions of Stalking*.

The most prevalent types of behaviour Mark used was recruiting other people and agencies in his stalking of Alicia. Mark contacted CSC 14x, harassed child 1 and 2's foster carer's, contacted the police, targeted Alicia's workplace, tracked her on social media, and she also reported she was scared he had been loitering outside her house. Evidence shows that stalkers will involve up to 21 people around the victim[48], and this includes professionals. The types of information Mark were sending agencies was sexually explicit in nature and designed to denigrate and degrade Alicia, he was not only accusing her of using drugs and being involved in the sex industry, he also accused her of child sex abuse, doctoring images to make it look like she was abusing children. The motivation here from Mark cannot be underestimated, it is depraved and shows his fixation on ensuring he gets the most revenge possible against Alicia. One can only imagine how distressed Alicia was about these accusations, but there isn't much information in the IMR data to evidence whether the impact was explored with Alicia. Although agencies agreed that Marks' accusations were unfounded Alicia was still investigated by the police and CSC, and it would have been very distressing for her to go through that. Despite all agencies believing Alicia over Mark, the impact of what he was accusing her of and the actions he was taking in her stalking against her should have been explored in more detail with her in relation to her mental health.

Throughout the IMR and chronology data numerous agencies commented on the fact that Alicia was difficult to engage, or did not pursue CJS options after an initial call out to police, but if we look at the bravery Alicia elicited in her continued support of the CJS case against Mark for the stalking, and her support of the previous NMO against Simon, we can see that she did support these processes.

The reality is that Alicia's experience of stalking was not taken as seriously as they should be, the impact on her mental health was not understood, and the response was so slow she never saw justice, because by the time Mark was convicted Alicia was already deceased. It is unsurprising that in the last few months of her life Alicia was frustrated with agencies, commenting to The You Trust SIDAS SPOC that there was nothing anyone could do to support her, she had fled to a refuge out of area, expressed how terrified she was, and been brave enough to advocate for herself through the police complaints system, but still Mark carried on his campaign of stalking undeterred. Any victim would feel trapped, desperate, and hopeless in this situation, and it is imperative that agencies are supported to join the dots and understand the risk stalkers pose both in terms of direct harm to the victim and the impact on a victim's mental health.

14.2 MARACs

Relevant TOR points:

[48] https://www.niassembly.gov.uk/globalassets/documents/justice/19-january-2017-presentation-by-laura-richards-paladin.pdf

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

There were several occasions where professionals completed DASH risk assessments on professional judgement because Alicia did not want to complete a DASH. Although all risk assessments have their flaws and understandably victims can be reticent to complete them, particularly in relation to re-living traumatic incidents, they are a useful tool to share information and monitor the context of a perpetrator's behaviour. Ultimately a victim that is deemed to be high risk of harm from a perpetrator will be heard at a MARAC and this is a good opportunity to share the risks to both victim and children, as well as address any actions that may not have been considered.

From December 2015 until May 2021 Alicia was discussed at MARAC on eight separate occasions, these are listed in the table below:

MARAC Information – Alicia

DATE/ Subject	REFERRER	INCIDENT	ACTIONS KNOWN	COMMENTS
December 2015 (SIMON)	Police	Simon broke into her property and smashed it up after an argument.	Referred to SIDAS Livewest IDVA service. Case heard at MARAC	N/A
September 2017 (SIMON)	Health visitor	Following incident where Simon was charged with 4 counts of assault and harassment and attacked both Alicia and her friend.	Referral rejected by MARAC twice – rationale is that the referral relates to an attack on a third party and CSC are already aware of risks to children. Case not heard at MARAC	Both HV team and SIDAS Livewest challenge this decision, with the latter keeping Alicia open because they are concerned about her risk.
May 2018 (SIMON)	Police	Referral made after incident where Simon attacked Alicia and she attended MIU after he hit her head against a door frame. Referral to SIDAS Livewest and MARAC.	One contact achieved with Alicia from SIDAS Livewest and target hardening of property addressed. Alicia reports being *'very frightened of Simon',* and working with MH services. No further contacts achieved.	N/A
July 2018 (ALICIA)	Police	Referral made by Police where Alicia was listed as the perpetrator of Simon. This was from third party information.	SIDAS Livewest challenge decision to list Alicia as perpetrator, given the history of DA from him towards her. SIDAS Livewest did not	N/A

			contact Simon as a victim, as no consent to contact.	
March 2019 (SIMON)	Police	Simon attacked Alicia in her flat. Alicia is pregnant with child 5 and when she tried to leave the property, he grabbed her by the neck and kicked her in the stomach.	SIDAS Livewest make contact with Alicia. She asks for support. Case closed after they are unable to contact Alicia from initial contact, although no record of how many times or what methods SIDAS Livewest use to contact Alicia. Of note that SIDAS Livewest prevent home visits due to Alicia previously being listed as a perpetrator – even though they contested this.	N/A
July 2019 (SIMON)	CSC	Alicia requested that CSC support her in getting a restraining order against Simon and asks that CSC do not step down their support for children. SIDAS Livewest do not received all information needed initially for MARAC referral, and	DASH listed at high risk with a score of 15. Violence and excessive jealousy listed as behaviours from Simon towards Alicia. Alicia declined support from SIDAS Livewest and she was not contacted.	N/A

		conversations continue between CSC and SIDAS until August 2019. CSC state this is more for information purposes for MARAC and Alicia is resistant to completing a DASH, but she agreed to allow CSC to complete it for her.		
September 2020 (MARK)	Stop Domestic Abuse – Portsmouth Refuge	The You Trust SIDAS received a referral from Stop Domestic Abuse, they also refer to MARAC. Alicia was due to return to Somerset after staying in the refuge having fled Stalking from Mark*.	The You Trust SIDAS service make contact with Alicia and she accepts support.	N/A
May 2021 (MARK)	Police	Referral to MARAC and The You Trust SIDAS in April 2021, not heard at MARAC until May 2021. Continued stalking and harassment from Mark. Alicia says she *'knows people are watching her house'* but police aren't taking her seriously. This	The You Trust SIDAS service make contact with Alicia, she expresses her frustration. The You Trust SIDAS raise concerns that this case is listed at MARAC for *'any other business'*	IDVA to clarify if Alicia is a victim of DA and Health and other agencies to see if there is any other information to report back to IDVA

		was one month prior to Alicia's death.		

*see notes from The You Trust SIDAS service on DASH disclosures

The rejected MARAC referrals in September 2017 were assertively challenged by SIDAS Livewest, and the rationale offered by the MARAC coordinator appear to be because there was an attack on a third party, namely Alicia's friend, this is not a DA case. This could have been analysed as an act of CCB, as targeting friends is a tactic used by some perpetrators to further isolate victims from support. Although A&SC work in multi-agency partnership with CSC during this period about the effects on the children, this is a missed opportunity to share the patterns of abuse Alicia is being subjected to from Simon, within the MARAC framework. Although the case did not result in a conviction against Simon, this is especially significant given he was charged with 4 separate offences as a result of this incident.

In addition, the counter-allegations where Alicia is listed as the perpetrator of Simon could have been an opportunity to explore the escalation in abuse within the family home. Alicia explained to SIDAS Livewest that she was terrified that she had grabbed a knife when she was arguing with Simon in May 2018, the next MARAC referral in July 2018 listed Simon as a victim and Alicia as a perpetrator.

January 8th, 2018, saw the release of the Domestic Homicide Review[49] into the murder of Katrina O'Hara on 7th January 2016 by her former partner (Mellor, 2018). The first police response into domestic abuse within this relationship was made on 10th November 2015 when both parties alleged, they had been assaulted. The victim admitted to throwing some of the perpetrator's stuff around. Within 58 days of making this report, the victim had been murdered. The DHR review made multiple recommendations but of note they concluded that the first police attendance was mislabelled. Reviewing Police Officers determined that that the victim was '*very much the perpetrator'* which changed the course of police responses. Ultimately, the victim's confidence in the agencies tasked to protect her was undermined.

The subsequent listing of Alicia as a perpetrator by SIDAS Livewest on their notes and the decision not to do home visits because of this fact, could have acted as a barrier to support for Alicia, especially given her mental health needs and the stresses she experienced looking after three young children, one of whom had autism. The labelling of victims as perpetrators needs to be done with significant care, and although it is important to challenge violence from any party in an abusive relationship, Alicia being labelled as the perpetrator could have been a catalyst for unconscious bias and victim blaming towards her.

Perhaps most concerningly the MARACs listed for Mark did not reflect the severity of the stalking he was subjecting her too. The notes from The You Trust SIDAS service IMR were the most useful to the review in reflecting Alicia's fear of Mark. In September 2020 they undertook an initial assessment with her following a referral from Stop Domestic Abuse in Portsmouth. The DASH contained the following disclosures from Alicia:

[49] https://www.independent.co.uk/news/uk/crime/domestic-abuse-police-katrina-ohara-failings-dorset-phone-taken-attacker-stuart-thomas-stalking-harassment-a8148726.html

22/09/20 Initial Assessment was completed face-face between IDVA1 and [Alicia]. The DASH that was completed at the referral was reviewed, there were no changes to the DASH and it scored 16, risk factors identified were:

- Frightened - turning up at property
- Afraid of further violence - being murdered
- Isolation – had to come off social media
- Depression and Suicidal – Alicia stated her kids were her protective factor and the only reason she wouldn't go through with it (suicide) is because she was worried no one will look after the kids
- Stalking/Harassment - persistently harassing me sending photos
- Recently had a baby – 9 months old
- Afraid of someone else – his parents
- [perpetrator] Hurt anyone else – his Dad and sister – but no details of what happened
- [perpetrator] Hurt an animal – the pet cat
- [perpetrator] Uses drugs – crack cocaine
- [perpetrator] Threats and attempts of suicide – no details of when this was
- [perpetrator] Broken Bail/Injunctions – yes – no details of what order and when/types of breaches
- [perpetrator] In trouble with Police – yes – no further details

The fact this case was questioned at MARAC and listed as 'any other business' indicates that Alicia was not being taken seriously in her fear of Mark. Considering she fled to a refuge out of area, and she was stalked for over a year and up until her death by an ex-partner, it is of significant concern that the final MARAC action was for the IDVA to explore whether there was 'any DA'. The missed opportunity and lack of understanding of the risks associated with stalking from ex-partners by all agencies is apparent in this review.

The panel noted the inconsistencies with the MARAC referrals and offer national recommendations in response, see section 16.

14.3 Children and Domestic Abuse

Relevant TOR points:

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Consider whether the Covid-19 pandemic affected the accessibility of services for Alicia and her family.

CSC were involved with the family for the duration of the review timeline period. The data pertaining to Alicia's two older children remaining in foster care and her sporadic visitation should be contextualised in the fact that Alicia did disclose to the GP that

Mark's stalking had an impact on her visiting her children and she was scared he would see her. Child 1 and 2's request to have supervised contact with Alicia because *'mum can be unpredictable at times'* - combined with Alicia's reluctance to agree to this supervision from February 2020 onwards - could be an indication of Alicia's declining mental health presentation in the latter years of her life. This was also at the beginning of the period of COVID19 lockdowns which could have been another reason for the cessation of contact with child 1 and 2. Irrespective, the lack of contact would have undoubtedly had an impact on both children and on Alicia.

CSC made significant efforts to highlight the impact of Simon's domestic abuse towards Alicia. It is clear there was a combined effort between health agencies, CSC, and the police to work with the family and address the domestic abuse in the home. It is also clear that this had an impact on behaviours with no further reported incidents of DA from Simon towards Alicia from July 2019, and an apparent settled relationship between the two of them with Simon having contact with child 4 and 5 from July 2019 until Alicia's death.

However, there was a lack of professional curiosity from agencies on the impact on the children of the stalking Mark subjected Alicia to from Mark 2020 until her death. We can see through the chronology and IMR data that Alicia and the children had a period of stability between the last reported incident from Simon in July 2019 and the stalking commencing from Mark in March 2020. From then the focus of the stalking appeared to be on the CJS process and assessments from specialist services about whether or not the case could be deemed to be DA. We can also see that Alicia's mental health declined rapidly in the last few months of her life, and several IMR author's including those from mental health, The You Trust SIDAS service, and the health visiting service, all commented on the lack of professional curiosity of the impact of stalking on Alicia's mental health.

Children are often 'unseen' and 'unheard'. We know that experiencing domestic abuse as a child often leads to lifelong trauma and health implications for victims and these can exist well into adulthood[50]. It is therefore vital that services respond rapidly to the needs of children living with parents who are subjected to domestic abuse, and this should include stalking.

Given that all three children were subject to child protection plans and ultimately removed from the care of Alicia, the voice of the children, however young, is incredibly important. Section 3[51] of the Domestic Abuse Act 2021 specifically states that any child under the age of 18 years who *'sees, hears, or experiences'* the effects of domestic abuse and is related to the victim or perpetrator, is the be regarded as a victim themselves. The intersecting needs of a victim of domestic abuse who is also the primary carer of three young children, one with special needs does not appear to have been noted in depth with

[50] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3869039/

[51] https://www.cps.gov.uk/cps/news/children-classed-domestic-abuse-victims-under-new-guidance#:~:text=Section%203%20of%20the%20Domestic,be%20regarded%20as%20a%20victim.

agencies dealings with Alicia, past the point of their interventions with Simon. It is also important to note that child 3 had a diagnosis of autism, and experts note that children on the autism spectrum often have difficulty talking about any traumatic experience they may have had[52], they also need specific responses in terms flagging their experiences to professionals[53].

It is clear that CSC were alert to the abuse the children were experiencing when Alicia was with Simon, and made steps to protect them, however this does not appear to have been prioritised when Alicia was being subjected to stalking from Mark. Further, there appears to be a lack of understanding of the risks associated with Stalking and its link to domestic abuse.

Due to other DHRs featuring recommendations regarding the impact of DA on children Somerset Council on behalf of the SSP have developed an online learning Foundation Programme on Domestic Abuse and a number of the modules explore the impact living with domestic abuse has on children. All professionals including Safeguarding Leads in school are encouraged to access relevant training provided by the Safer Somerset Partnership, to strengthen their knowledge and understanding.

14.4 Suicide Domestic Abuse and Stalking

Relevant TOR Points:

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

Research published in February 2023 published by Agenda Alliance[54] reveals that:

- Women who experienced abuse from a partner are three times more likely to have made a suicide attempt in the past year, compared to women who have not experienced abuse.
- Women living in poverty are especially at risk.

[52] https://www.kennedykrieger.org/stories/potential-magazine/fallwinter-2019/identifying-trauma-children-autism
[53] https://www.autismspeaks.org/recognizing-and-preventing-abuse
[54] https://www.agendaalliance.org/about-us/

- Sexual abuse puts victims at raised risk of self-harm, suicidal thoughts and suicide attempts.[55]

It is imperative that organisations nationally are supported to understand how to approach the risk of suicide for victims of domestic abuse better:

> Historically, the focus in suicide prevention has been on men due to their longstanding higher suicide rate. However, this has led to a worrying lack of understanding of the growing rate of attempted suicide and self-harm among women and any link with domestic abuse.[56]

This is particularly important for professionals to understand in terms of domestic abuse victims and the link to suicide. As research states[57]:

> ...cross-sectional, prospective and retrospective studies have consistently demonstrated that living with a violent intimate partner is a significant contributor to women's adverse mental health outcomes. The most prevalent sequelae include depression, anxiety and Post-Traumatic Stress Disorder (PTSD). Furthermore, intimate partner violence is strongly associated with suicidality, sleep and eating disorders, low self-esteem, personality disorders, social dysfunction and an increased likelihood of substance misuse...

The UK government's recent Domestic Abuse Action Plan[58] has expressed "concern" about the effects of domestic abuse on suicide, it notes:

> "It is devastating to know that those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide".

But as specialist researchers in the field of domestic suicide reviews point out[59]:

> "...it is equally important to underscore that this [suicide] is not an inevitability, and there is much that can be done through improved training, risk assessment and support provision tailored to this context."

Increased awareness is being highlighted on victims who die by suicide, for example, in the recent coroner's report after the tragic death of Lauren Murray[60] in Greater Manchester. This case should focus professionals' minds to the potential for victims who

---

[55] https://www.agendaalliance.org/news/new-figures-reveal-link-between-suicidal-thoughts-and-domestic-abuse/

[56]

[57] https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-10-98

[58]

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064427/E02735263_Tackling_Domestic_Abuse_CP_639_Accessible.pdf

[59]

https://warwick.ac.uk/fac/soc/law/research/projects/999368_law_domestic_violence_main_research_report_final_final_pre-print.pdf

[60] https://bhattmurphy.co.uk/files/SRN%20cases/05.01.23%20SRN.pdf

die by suicide and or use self-harm as a coping mechanism in dealing with the trauma of domestic abuse.

The records show that Alicia had used substances in the past and we know she had a diagnosis of borderline personality disorder. Towards the end of Alicia's life PHN noted the links between her own Adverse Childhood Experiences (ACEs) and her diagnosed mental health issues.

Adverse Childhood Experiences[61] (ACES). ACES are potentially traumatic events that occur in childhood (aged 0-17). Examples[62] of ACES include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Living with someone who abused drugs
- Living with someone who abused alcohol
- Exposure to domestic violence
- Living with someone who has gone to prison
- Living with someone with serious mental illness
- Losing a parent through divorce, death or abandonment

ACES can impact on a child's future physical and mental health as an adult and include the increased potential for being a victim of violence, becoming violent, and an increase in mental health problems. Research[63] has revealed the longer a child experiences an ACE and the more ACES a child has the bigger the impact will be on their mental health.

The combined factors of ACEs, mental health, and substance use are important to note because multiple disadvantages exacerbate victims' vulnerabilities. Research commissioned by the Home Office and published in July 2022[64], analysed 32 separate DHRs where the victim had died by apparent suicide. The findings were concurrent with much of Alicia's experience, and included:

- 67% of victims who had presented signs of suicidal ideation and / or made prior suicide attempts before their death, also had a history of self-harm.
- Where there was alcohol and / or substance abuse documented on the part of the deceased within the DHRs, there were also often signs of consistent self-neglect and deteriorating mental health. 50% of victims had experienced challenges associated with drug and alcohol misuse, and in all cases, this served - in different and sometimes complex ways - to aggravate other vulnerabilities.

---

61 https://www.cdc.gov/aces/about/index.html#:~:text=Adverse%20childhood%20experiences%2C%20or%20ACEs,attempt%20or%20die%20by%20suicide.

62 https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/

63 https://www.sciencedirect.com/science/article/abs/pii/S0749379798000178

64 https://warwick.ac.uk/fac/soc/law/research/projects/999368_law_domestic_violence_main_research_report_final_final_pre-print.pdf

- Amongst the findings that our sample of DHRs most clearly reveals, then, is that victims were often navigating a variety of complex vulnerabilities and needs, and frequently doing so, moreover, in the plain sight of statutory services. Just over half of the victims had engaged with specialist domestic abuse services, almost two-thirds had engaged with mental health and / or counselling services, and similar proportions had attended hospital or A&E services in conjunction with their abuse, with three-quarters known to have also been in at least relatively regular contact with their GPs. Notwithstanding the higher rates of drug and / or alcohol dependency indicated in the DHRs, less than 30% of victims had accessed support from specialist addiction services.
- Periods of uncertainty in accessing long term mental health support after speaking with GPs often resulted in a faster deterioration of victim's mental health and long waiting lists for services were common.
- ...there was also often evidence of failures to empathise with the barriers to engagement that victims might encounter or to work creatively to overcome them, even where that non-engagement was reflective of worsening mental health or the entrenchment of pre-existing vulnerabilities or abuse.
- Where there is a history of domestic abuse, withdrawal from specialist mental health services ought to be treated with caution, as a trigger for exploration, action, and engagement, rather than interpreted as an autonomous decision representing victim disinterest or a lack of pressing need.

The links between stalking and mental health are well researched with the Royal College of psychiatrists noting[65]:

> Stalking is always anxiety provoking and if it continues, it usually causes psychological and social damage to the victim. Stalking can produce a state of chronic fear which disrupts concentration, sleep and effective function as well as causing the victim to reduce their social activities. Prolonged stalking is associated with the emergence of depressive and chronic anxiety symptoms, with suicidal ruminations in up to 24% of victims. Victims of stalking, like many other types of victims, tend to blame themselves despite bearing no responsibility for what is being done to them.

We know for Alicia that she felt suicidal on occasion and that a protective factor for her was her children which she mentioned on several occasions throughout the timeline period, including to her GP and the mental health team. In July 2020 Alicia told CSC when she was struggling to cope with her children that she would never hurt her them but wanted *"go away on her own and put a noose around her neck"*. This is particularly pertinent given this was five months after Mark started stalking Alicia, and under a year later Alicia completed apparent suicide by hanging.

---

[65] https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/pss/pss-guide-11-stalking.pdf?sfvrsn=2f1c7253_2#:~:text=Stalking%20is%20always%20anxiety%20provoking,re%2D%20duce%20their%20social%20activities.

Alicia also told The You Trust SIDAS service that she was feeling suicidal in her last contact with them in May 2021, but that "*her kids were her protective factor and the only reason she wouldn't go through with it (suicide) is because she was worried no one will look after the kids"*.

Unfortunately, a month later Alicia had a mental health crisis, and she went into hospital under a voluntary section. During that time child 3 was placed in the care of the local authority and child 4 and 5 were placed with Simon. Alicia was very distressed that she would not get her children back, and given they were a protective factor, it is a missed opportunity that this was not explored by the mental health team at the hospital when she was released.

The hospital team assessed Alicia's mental health to be behavioural and although Alicia at one point said she *'was not suicidal but just fucked off'*, on release Alicia then said she would tell the police she was suicidal, but the hospital deemed this not to be a credible threat. The stark facts are that ten days after her hospital release Alicia died by apparent suicide.

It is clear that for Alicia the links between DA and suicide risks were not well understood by professionals, but fortuitously the recent research by Agenda Alliance comes with a list of robust recommendations[66]. In addition, research into domestic homicide reviews that involve suicide by Advocacy After Fatal Domestic Abuse[67] has resulted in a series of practical resources for practitioners on the risk of suicide after domestic abuse. The panel support the recommendations of a previous DHR of both these pieces of research for Somerset, where appropriate, and will further make a national recommendation for the consideration in other areas.

In addition, as a result of this DHR/DHR, Somerset NHS Foundation Trust will be undertaking an audit of cases of suicide known to the Trust over a two-year period to determine whether those individuals were known to be victims of domestic abuse and if there were coexisting factors such as multiple complex needs and disadvantage and whether they had children residing with them or removed from their care. It is hoped the findings of this audit will identify whether current risk assessment of individuals presenting with suicidal ideation, or attempts is sufficient or whether current risk assessment process needs to be reviewed and updated. A summary of the findings will be included in the 2024/25 Safeguarding Adults Annual Report and shared with local stakeholders via the Trust's Safeguarding Committee.

14.5 <u>The impact of COVID19 on Victims of Domestic Abuse</u>

[66] https://www.agendaalliance.org/news/new-figures-reveal-link-between-suicidal-thoughts-and-domestic-abuse/
[67] https://aafda.org.uk/learning-legacies

Relevant TOR points:

- Consider whether the Covid-19 pandemic affected the accessibility of services for Alicia and her family.

We can learn from the emerging findings of research[68] of the impact the pandemic had on victims and survivors of domestic abuse. The research notes:

- Isolation is a major theme in the literature, with isolation leading to increased personal safety needs of victim-survivors. One of practitioners' biggest concerns was the safety of isolated survivors due to the lack of face-to-face provision and increased risk from perpetrators. Large proportions of victim/survivors reported that they had been cut o from support networks and help-seeking avenues.
- Mental health is a prominent theme, both for victim-survivors currently experiencing abuse and those having experienced abuse in the past, with several references to increases in suicidal ideation.

We know that Alicia struggled with anxiety about sending child 3 to school during the pandemic and this would have increased on the pressures at home having to cope with all three children. CSC and the school did provide extra support to Alicia during this time and that should be commended.

As already discussed, the delays in the CJS process occurred during the pandemic and the impact of this on Alicia was significant. The delays in victims seeking justice which were exacerbated by the pandemic because of an already under resourced CJS continues to this day.

In addition, research[69] undertaken on the national stalking service Paladin[70] during the pandemic revealed there were particular consequences for victims of stalking in lockdown periods. The victims interviewed highlight a number of concurrent themes with Alicia's experiences:

> The various forms of social isolation created by stalking were a prominent feature across all interviews. Isolation was exacerbated by lockdown measures, particularly if victims were reluctant to use or trust digital technology. Social isolation was a prominent feature in service users' accounts...
>
> Evidence documenting the detrimental impact of the COVID-19 pandemic on mental health in the general population is accumulating. Infection fears increased financial pressures, caring responsibilities and uncertainty about the future characterises anxiety in the general population and compounds existing anxieties and fears felt by stalking victims. Victim surveys undertaken prior to the pandemic demonstrate the negative impact of stalking on mental health and wellbeing with the fear instilled by stalking behaviour a significant predictor of PTSD symptoms. The unpredictability of the COVID-19 outbreak will inevitably

[68] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf
[69] https://link.springer.com/article/10.1007/s10896-020-00201-0
[70] https://www.paladinservice.co.uk/

heighten existing mental health difficulties. Added concerns for personal safety, financial stresses and restricted access to support brought about by the pandemic and resulting measures, intensify the fears and senses of loss of control reported by stalking victims.

Recommendations from the above research include the importance of raising awareness amongst professionals of the impact of stalking, the law, and the specialist provision available to victims – all of which are pertinent to the learning for this review.

15. Key findings and Conclusions

Coercive Control and Stalking – Alicia's experience of being subjected to abuse by two separate partners during the timeline period unsurprisingly had an effect on her mental health. Her experience of the criminal justice system was inadequate in parts, and this cannot simply be excused by the COVID19 pandemic. Throughout the review the lack of understanding of the legislative tools available to keep Alicia safe via a Stalking Protection Order were noticeable.

MARACs – Alicia was discussed at MARAC on eight separate occasions over the timeline period. Three occasions related to Simon, two related to Mark, and on one other occasion Alicia was listed as a perpetrator against Simon after a counter-allegation against her. This latter fact was ultimately dismissed in the context of Simon being the primary perpetrator, but it had an impact on the ways in which Alicia was treated and there is an indication that it could have contributed to unconscious bias against her, which crucially could have impacted on her mental health and help seeking abilities. The MARACs scheduled to discuss Marks stalking were not given the requisite attention with the final meeting placing Alicia's experience as 'any other business', and there were missed opportunities to holistically assess the context and risk of Mark's stalking behaviour within a multi-agency setting. The rejection of MARAC referrals from the health visiting team were not adequately justified given the context of Alicia's experience of being subjected to abuse and the risk factors associated with her vulnerabilities.

Children and Domestic Abuse – It is clear from the data revealed from agencies and from talking with Alicia's family that she dearly loved all her children, and she did her best in difficult circumstances to keep them safe. Children and young people are often unseen and unheard within domestic abuse cases and the review revealed that on the whole Simon's behaviour was addressed well by agencies, but this was not the case when Mark began his campaign of stalking against Alicia. The deterioration in Alicia's mental health was significant during the last year in her life and there was little triangulation to link Mark's stalking of her and her subsequent ability to care for the children. The impact of stalking must be understood in the context of trauma responses – stalkers infiltrate a victim's whole life and the impact on their ability to function, including when parenting will naturally be impacted. Alicia repeatedly told agencies she was scared of Mark, she fled to a refuge, and she took her 3 youngest children with her – of course the children

would be scared too and the upheaval in their lives because of Mark's behaviour was undeniable.

Suicide Domestic Abuse and Stalking – The links between the increased risk of suicide in victims of domestic abuse is better understood at the point of writing the review which is over 3 years after Alicia's tragic death. Alicia's experience provides a stark reminder of the importance of prioritising the risk of suicide in victims of domestic abuse and stalking. This risk was particularly relevant when taken in the following context:

- Alicia's Adverse Childhood Experiences (ACEs)
- Alicia's existing mental health diagnosis
- The long-term abuse Alicia had been subjected to by two separate partners
- Alicia's two older children already being in care and coping with three young children at home – one of whom had significant care needs
- The degradation Mark used in his stalking campaign against Alicia, including public claims of Alicia being a sexual offender of children
- Alicia having to resign from her job because of Mark's stalking
- Alicia's experience of the criminal justice system
- Alicia's fear of not getting her youngest three children back after she was sectioned for a mental health crisis

Alicia told professionals intermittently she felt suicidal throughout the timeline period, most notably ten days prior to her death. The reality is that professionals did not take seriously the credibility of Alicia's threats of suicide or understand the context and background of the increased risk of her vulnerability in this regard.

The impact of COVID19 on Victims of Domestic Abuse – The impact of COVID19 is beginning to be understood by professionals but the long-term consequences are still revealing themselves. During lockdown Alicia was coping with three young children at home, and she was very nervous about sending child 3 to school because of the virus. Although social care did support her through these anxieties and offered extra help, Alicia ultimately had to cope at home on her own with her children. At the same time Mark continued his campaign of stalking against her, and we know for victims of stalking the pandemic heightened their fears[71] and mental health outcomes. The delays in the criminal justice system during the pandemic had significant impact on victims and Alicia's experience meant she was not here to see Mark convicted of stalking her as the court case was heard after her death. The panel note that the delays in the CJS created by the pandemic for victims of stalking and domestic abuse continue to this day.

Family Voice

[71] https://www.paladinservice.co.uk/

The family were able to provide the chair with their observations after reading the review and the final thoughts will be reserved for them:

Alicia's dad:

Alicia's dad noted the significant impact Mark's stalking had on her and the children. He remembered the postponed harassment case due to COVID19, which resulted in a delay from charge to court of over a year, had *"a really big impact"* on Alicia's wellbeing and ultimately, she was not alive to see justice being served. He also commented on the fact that having to resign from her job due to Marks stalking was very distressing for Alicia. Her dad noted that she *"loved her job"* and *"was really good at it."*

After digesting the full review Alicia's dad made some clear observations which are important to record in full:

> "I can't understand why Alicia was only ever offered civil injunctions and Mark wasn't arrested and pursued more robustly. I was also really shocked to read that Alicia was listed as 'any other business' on the MARAC list, she was a victim and was treated like an afterthought.
>
> I also wonder if Alicia was ever assessed for PTSD; many women who are diagnosed with PTSD look like they won't engage with services, but that is because they have been let down and have experienced violence and abuse so it could be trauma related rather than personality related. The trauma she experienced especially from the stalking impacted everything in her life and her kids were also badly impacted – it's a lifetime of generational trauma for them."

Alicia's sibling:

Alicia's sibling was kind enough to contribute to the review and gave the following observations and thoughts:

> "More could have been done to support Alicia with her mental health issues; I even phoned up myself with regards to her safety and ability to look after the children with a decline in her mental health. This was only a couple of weeks before my sister's death, they asked is she a danger right now? I said no but she could be.
>
> I think lot of abuse happened without my knowledge and my sister didn't want me to find out…I believe the constant stalking and bothering of my sister did and would impact my sister's well-being and mental health. I did see my sister's mental health deteriorating over the years, and I would visit my sister about 2 or 3 times a year.

I believe my sister could have been helped more from the government or agencies even when I phoned up…there was nothing they could do I would have thought preventive measures would be than letting things getting out of hand."

The above observations provided the panel with the much-needed focus to develop recommendations. Alicia's dad was also involved in the development of these recommendations.

16. Recommendations

Single Agency Recommendations

All single agency recommendations were accepted by the panel and are reflected in the action plan (section 16). Given the time delay on the review, all single agency recommendations were completed before the second author was commissioned.

At the time of the review A&SC did not attribute any single agency recommendations for the review. The second author would have challenged this decision, most notably in relation to criminal justice responses for stalking victims, and risk assessing victims with multiple disadvantages including substance use and or mental health. However, the passage of time has meant that many of the recommendations relevant at the time of Alicia's death have been raised in other reviews both in the force area and in terms of national police responses to victims. The panel were therefore satisfied that the multi-agency recommendations below incorporate any additional learning for A&SC in addition to the changes that have already been made in policy and practice across the force since June 2021.

Multi-Agency Recommendations:

The delay in this review has resulted in other DHRs addressing many of the recommendations needed for children as victims of DA. The panel were therefore satisfied that the learning needed to address the issues that arose for children within this review are already underway within Somerset and significant changes have already been implemented.

The panel agreed on the following multi-agency recommendations:

- Raise awareness of risk escalation and identification in stalking and DA cases – via MARAC rep training
- Incorporate learning DHR045 and this DHR for professionals to gain insight into the connection between domestic abuse/stalking and the risk of suicide.
- Public awareness campaign during National Stalking Awareness Week – to include promotion of independent specialist stalking services that can support victims to explore legal and emotional support options.

- Feedback to family regarding progress of recommendations.

National recommendations:

- Highlight links between DA/Stalking and risk of suicide with DA commissioner for England and Wales.
- Send the published review to The National Stalking Consortium to highlight the need for research into risk for children in stalking cases including but not ltd to assessing access to children from the stalker via child contact.
- Send the published DHR to the Legal Services Consumer Panel[72] using Alicia's story to highlight the need for victims of DA to understand their rights and access to legal aid.

[72] https://www.legalservicesconsumerpanel.org.uk/

17. Action Plan (working document)

DHR 041 Action Plan

Single Agency Recommendations/Action Plan

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
Public Health Nursing (PHN) service to ensure that records are requested for all families with pre-school children known to have moved into Somerset.	Local	Audit records of UPP families known to have moved into Somerset. Summaries of previous concerns and actions together with Family Health Needs Assessment should inform onward care.	Public Health Nursing	N/A	N/A	Completed
To record all incidents of domestic abuse, regardless of how insignificant they appear	Local	Professionals to be reminded to record all incidents and review chronologies. Chronologies - in families where there is domestic abuse, even the most insignificant incident can help understanding of what is going on and can identify patterns and gaps.	CSC	N/A	N/A	Completed
All incidents should be analysed using **S**ituation, **B**ackground **A**ssessment **R**ecommendation tool	Local	Audit records. To inform actions required by Public Health Nurse practitioner.	PHN	N/A	N/A	Completed
For all families classified as Universal Partnership Plus child health reviews should be	Local	Review current practice against standard operating procedures. Specialist skills required for in depth assessment	PHN	N/A	N/A	Completed

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
completed by a Public Health Nurse.						
Pathway for people with Borderline Personality Disorder	Local	Mental Health Services to develop pathway Training to appropriate services. To recognise and understand behaviours of adults diagnosed with BPD which in turn will inform requisite action.	Mental Health (And all appropriate services)	N/A	N/A	Completed
When a patient attends the GP with evidence of bruising or an injury GP to show professional curiosity.	Local	Health Module has been developed as part of Domestic Abuse Training by SSP, in line with previous DARDRs Webinar to be created by SAR subgroup learning and development based on professional curiosity and promoted through Primary Care. Actual bruises observed by the GP should be addressed with sensitive conversation.	ICB, SSP working with SSAB	N/A	N/A	Completed
Remind MIU's about the domestic abuse referral pathway and Policy	Local	Via safeguarding supervision and memo to Service Managers. Refresh staff awareness of DA process & policy	SFT Named professional safeguarding adults / domestic abuse coordinator	N/A	N/A	Completed
For HTT's and CMHS to be reminded of the importance of chronological information in risk assessment and how coexisting stressors can impact on an individual's capacity to cope.	Local	Raise via safeguarding supervision and memo to service managers. To review clinical risk management training	SFT Named professional safeguarding adults	N/A	N/A	Completed

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
		To ensure holistic risk assessment				
PIU admission checklist and discharge checklist to include professional curiosity on admission, and risk assessment on discharge to include consideration of domestic abuse.	Local	To review and update PIU admission checklist and discharge checklist As a means to start to embed domestic abuse routine enquiry	SFT Named professional safeguarding adults	N/A	N/A	Completed
To produce and circulate a 7-minute briefing document outlining the concept of confirmation bias.	Local	To write 7-minute briefing To raise awareness across SomFT of the concept of confirmation bias	SFT Named professional safeguarding adults	N/A	N/A	Completed
Staff training on Outcome Star	Local	Training to be developed and delivered to all Paragon staff To highlight importance of addressing all areas where support needs are identified	YOU Trust Paragon Manager	N/A	N/A	Completed
Training on importance of reviewing all referral information prior to appointment with a client and that DASH's completed by other agencies are reviewed.	Local	Training to be developed and delivered to all Paragon staff. To ensure that all risks are identified and actions are put in place to reduce risks	YOU Trust Paragon Manager	N/A	N/A	Completed
MARM Meetings to be considered for cases whereby usual support channels are not proving effective.	Local	Reminders for Managers to consider MARMMs during case management or MARACs MARAC does not achieve required outcomes for all cases and other routes need to be considered	YOU Trust Paragon Manager	N/A	N/A	Completed

Multi-Agency Action Plan

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
Raise awareness of risk escalation and identification in stalking and DA cases – via MARAC rep training	Local	Share review with MARAC reps via training and raise this as a case study for learning. Highlight stalking as a high-risk factor in DA cases, both in terms of risk of harm and of suicide	CSP	Develop training Deliver training	June 2025	Completed
Incorporate learning DHR045 and this DARDR for professionals to gain insight into the connection between domestic abuse/stalking and the risk of suicide	Local	Design a 7-minute briefing with links to Agenda Alliance and Learning Legacies included. Raise profile of work on links between DA and suicide, and include stalking as a risk factor in potential suicide.	CSP	Review both reports and develop learning briefing Disseminate via newsletters and other briefings with local statutory partnerships	April 2025	Completed
Promotion of independent specialist stalking services that can support victims of stalking to explore legal and emotional support options	Local	Public awareness campaign during National Stalking Awareness Week – April 2024. Empower victims of stalking to seek independent support and explore all their options.	CSP	Develop campaign materials Develop promotional strategy	April 2025	Completed
Feedback to family regarding progress of recommendations	Local	Feedback on recommendation action plan – 1 year after publication of review Ensure victims family are kept informed of the continued learning from the review	CSP	Feedback to family	1 year after publication of review	November 2026

National Recommendations

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of Completion
Highlight links between DA/Stalking and risk of suicide with DA commissioner for England and Wales.	National	Flag review with DA commissioner's office on publication Raise the profile of the links to DA / Stalking and suicide.	CSP	Write and send letter to DA Commissioner for England and Wales	On publication	November 2025
Send the published review to The National Stalking Consortium to highlight the need for research into risk for children in stalking cases including but not ltd to assessing access to children from the stalker via child contact.	National	Send published review to national stalking consortium to suggest a focus on the impact of stalking on children and young people during national stalking awareness week.	CSP	Send review highlighting the recommendation to National Stalking Consortium – Suzy Lamplugh Trust	On publication	November 2025
Send the published DHR to the Legal Services Consumer Panel[73] using Alicia's story to highlight the need for victims of DA to understand their rights and access to legal aid.	National	Send published review to Legal Services Consumer Panel	CSP	Send review highlighting the recommendation to CEO at Legal Services Consumer Panel.	On publication	November 2025

[73] https://www.legalservicesconsumerpanel.org.uk/

18 . Appendices

Appendix A

Terms of Reference

TERMS OF REFERENCE FOR REVIEW PANEL

DHR 041

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of a 34-year old woman. The death is believed to be suicide, with the person causing harm being her ex-partner(s).

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death in June 2021 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies;
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
  - analyses and comments on the appropriateness of actions taken;

- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider the period from January 2016 to June 2021, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant. Organisations however are asked to check their databases from 2011 for any significant interaction.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Ensure that the role of the children and family members are considered carefully as part of this review as a key factor in the build up to the death. The review needs to ensure the safeguarding of the children whilst ensuring the review recognises the significant impact they played in their Mother's life.

- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers Ms Doyle or her family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the

family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the sex, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Consider whether the Covid-19 pandemic affected the accessibility of services for victim and her family.

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSP Chair)

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency	Representative

Independent Chair	
Avon and Somerset Police	
Clinical Commissioning Group	
Children's Social Care	
Safer Somerset Partnership (SCC Public Health)	
Somerset Integrated Domestic Abuse Service (The You Trust – 2020 +)	
Somerset Integrated Domestic Abuse Service (Livewest Housing – 2015 to 2020)	
Somerset NHS Foundation Trust	

This was confirmed at the first Review Panel meeting on 16 December 2021

5.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

6 **Outline Plan for DHR** (subject to change depending on information found during the review) – Please note 1 day equates to 7 hours.

November 2021	○ Independent Chair appointed by Safer Somerset Partnership	
November 2021	○ Independent Chair establishes ToR and timetable with Safer Somerset Partnership	
December 2021	○ First Review Panel meeting ○ IMRs/chronologies to commence	○ ½ Day

December 2021	○ Liaison with Police, Coroner, relatives and friends	○ 2 ½ Days
February 2022	○ IMRs (with chronologies) returned	○ 1 Days (review by Chair)*
February 2022	○ Second Panel Meeting	○ ½ Day
March 2022	○ Further interviews with family/friends	○ 2 Days
April 2022	○ Draft report to be circulated via email.	○ 3 Days (collation of report)
May 2022	○ Review Panel Meeting (to agree report and recommendations)	○ 2 ½ Days (including any final revisions of report)
June 2022	○ Overview report to be submitted to the Safer Somerset Partnership Chair and signed off / sent to Home Office	○ ½ Day

6.1 It is envisaged that this review will take the appointed DHR Chair no more than 12 ½ days (87.5 hours), (as indicated above).

6.2 *The chronologies will be compiled by SCC to assist the Chair in analysis.

7 **Liaison with Media**

7.1 Somerset County Council as lead agency for domestic abuse for the Safer Somerset Partnership will handle any media interest in this case.

7.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

Domestic Homicide Review

Executive Summary

Safer Somerset Partnership

Report into the death of Alicia

June 2021

Author – Dr Shonagh Dillon, LLB, DCrimJ

January 2025

Contents

1. Executive Summary

1.1 Tribute

I want to honour the life of my daughter, Alicia, a light that will forever shine in my heart. Though she is no longer with us, the memories she left behind will continue to fill me with love, warmth, and gratitude for the time we had together. Alicia was more than my daughter—she was my joy, my laughter, and a part of my soul that will always remain.

From the moment she came into this world, Alicia brought a sense of wonder and happiness to those around her. She had a beautiful smile that could light up any room, and her laughter was infectious. She had a way of making even the smallest moments special, like how she'd dance around the kitchen when a song she loved came on, or the way she'd curl up with a book, completely lost in its pages, only to stop and share a story with such enthusiasm. Her love for life was evident in every little thing she did.

One of my fondest memories is watching Alicia grow into the remarkable person she became. She was full of creativity and curiosity. As a child, she loved to draw, filling page after page with her vibrant imagination. She had a way of seeing beauty in the world that others might overlook, and she expressed that beauty in everything she did. Whether it was through art, her love of nature, or the way she cared for those around her, Alicia had a heart that was open and generous. She cared for so many people and would randomly chat with strangers.

Alicia was someone who embraced life fully. She loved just talking about everything and nothing. I remember the joy in her eyes when she saw something new, whether it was a beautiful sunset, the moon, or simply the beauty of the world around her. Those are the moments I will carry with me forever—the sound of her voice, the way she would point something out with such excitement, and the joy of simply being with her and dining on her incredible roast dinners.

There are so many little things I miss—her gentle teasing, her phone calls just to check in, and her thoughtful nature. Alicia was the kind of person who would go out of her way to make someone feel loved. She never missed a birthday, and her gifts were always chosen with such care, reflecting her deep understanding of what made each person special. Her kindness wasn't something she reserved just for those closest to her—it was something she extended to everyone she met.

Though her journey ended far too soon, the love, laughter, and joy she brought into our lives will never fade. I will always remember Alicia as the incredible daughter. She had her struggles but those do not define who she was. What defines her is her love for her children, her passion, her creativity, and the way she touched everyone she met.

Alicia, I miss you more than words can say. You will always be my little girl, the one who brought so much happiness into my life. I will forever cherish the memories we created, the laughter we shared, and the love that will never leave my heart. I hope you have found peace, my sweet Alicia, and know that you are remembered every day with love.

Dad

I hope that this report will highlight the need for better multiagency understanding about the impact of stalking, by raising awareness, preventing harm, and addressing dangerous behaviour before it escalates.

1.2 Preface

The independent author, Domestic Homicide Review (DHR) panel and the Somerset Community Safety Partnership (CSP) wish to offer their deepest condolences to everyone who was affected by Alicia's[74] death. We extend our further thanks to those who knew Alicia and contributed to this review, their generosity in doing so, considering their loss, is greatly appreciated.

In addition to this the author and the panel would like to extend our thanks to all professionals who responded to the Individual Management Reviews (IMR), the time and effort taken to complete these to a good standard enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincere thanks to the panel members for their professionalism and the considered manner in which they approached this review.

1.3 Domestic Homicide Review

This review will examine the circumstances surrounding the death of Alicia, aged 34, who died by apparent suicide in June 2021.

The referral from Somerset NHS Foundation Trust was sent to the CSP in June 2021. The decision to undertake a DHR was made by Somerset (CSP) on 25th July 2021. The Home Office was subsequently informed.

An independent chair was appointed by the Safer Somerset Partnership (SSP) in October 2021. Unfortunately, after commencing the review, the independent chair experienced a succession of significant personal issues, and despite extensive efforts and negotiations between the Safer Somerset Partnership and this chair to conclude the review, the decision was made in Spring 2024 that the former chair could not complete the review.

In May 2024 the CSP re-commissioned the DHR to a new chair, Dr Shonagh Dillon who undertook the role of independent author and chair to the panel and the DHR panel was re-convened. Due to the delay in the review being completed Dr Dillon made the decision to write a draft review before meeting with the panel to discuss the analysis and

[74] Not her real name

recommendations of the review. The purpose of this was to prevent any further delay with the coroner's inquest and most importantly to prevent any further delays for the family, who the panel all agreed have waited far too long for the closure of this review.

The panel members met on the following dates:

- DATES (previous chair) 16th December 2021, 18th March 2022, 12th May 2022, 27th July 2023

- Dates (second chair) 28th August 2024, 9th December 2024.

The overview report and executive summary were presented to the SSP CSP board for approval on 8th January 2025 and submitted to the Home Office on 13th February 2025. The report was considered by the Home Office Quality Assurance Panel on 30th September 2025 and approved for publication in November 2025.

1.4 Contributors to the review

The author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

Dr Dillon is a Home Office accredited DHR chair and has nearly three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. It is worth noting that the IMR author for CSC was line manager for one of the social workers and the team manager, but she did not have direct contact with any of the subjects and her independence was agreed by the previous chair. None of the other panel members were the immediate line managers of anyone who engaged with the parties subject to this review.

Panel Members
Chair and Author – Dr Shonagh Dillon, LLB, DCrimJ
Somerset NHS Foundation Trust - Strategic Lead & Named Professional for Safeguarding Adults
Children's Social Care – Strategic Manager Operations Children with Disabilities
The You Trust – Assistant Director Paragon (SIDAS services) – DA expert panel member
Senior Commissioning Officer (Interpersonal Violence) Somerset County Council

Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team
Deputy Designated Nurse for Safeguarding Adults – Somerset ICB
Detective Chief Constable – Avon and Somerset Constabulary

The chair would like to thank all professionals involved in this review; their time, effort and cooperation was exemplary.

1.5 Terms of Reference

The Terms of Reference guidance set out the purpose and the scope of the review, and the panel focused specific questions to each agency whilst undertaking the analysis of their involvement. The questions were as follows:

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are

subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Consider whether the Covid-19 pandemic affected the accessibility of services for Alicia and her family.

1.6 Summary Chronology/Facts

Alicia was a 34-year-old female, who had an extensive history of being subjected to domestic abuse and stalking from both her previous partners, Simon[75] and Mark[76]. Alicia was known to mental health services and had been given a diagnosis of borderline personality disorder (BPD) in January 2020. BPD is also referred to as emotionally unstable personality disorder (EUPD), with rapid mood changes. Her initial relationship with Mark resulted in them having the children removed into local authority care, where they remained until her death. The reasons for the removal of her children included the domestic abuse she was being subjected to from Mark. In 2014 Alicia met Simon and agencies first became aware of her as a victim of domestic abuse from Simon in 2016. From that time on until July 2019 services worked with Alicia and Simon to address his abuse towards her and the impact on the children.

From July 2019 until March 2020 Alicia had a period of stability in her life with no further reports of domestic abuse. But in March 2020 Mark started a campaign of stalking Alicia after eight years of no contact with her. The stalking continued until her death in June 2021.

During the last year of her life Alicia's mental health declined and she found it hard to cope with three young children, one of whom had a diagnosis of autism. It is clear Alicia loved her children very much, but in May 2021 Alicia was taken to a place of safety on a mental health inpatient unit where she was assessed and admitted. In June 2021 Alicia died by apparent suicide, may she rest in peace.

1.7 Key Findings and conclusions

Coercive Control and Stalking – Alicia's experience of being subjected to abuse by two separate partners during the timeline period unsurprisingly had an affect on her mental health. Her experience of the criminal justice system was inadequate in parts, and this cannot simply be excused by the COVID19 pandemic. Throughout the review the lack of

[75] Not his real name
[76] Not his real name

understanding of the legislative tools available to keep Alicia safe via a Stalking Protection Order were noticeable.

MARACs – Alicia was discussed at MARAC on eight separate occasions over the timeline period. Three occasions related to Simon, two related to Mark, and on one other occasion Alicia was listed as a perpetrator against Simon after a counter-allegation against her. This latter fact was ultimately dismissed in the context of Simon being the primary perpetrator, but it had an impact on the ways in which Alicia was treated and there is an indication that it could have contributed to unconscious bias against her, which crucially could have impacted on her mental health and help seeking abilities. The MARACs scheduled to discuss Marks stalking were not given the requisite attention with the final meeting placing Alicia's experience as 'any other business', and there were missed opportunities to holistically assess the context and risk of Mark's stalking behaviour within a multi-agency setting. The rejection of MARAC referrals from the health visiting team were not adequately justified given the context of Alicia's experience of being subjected to abuse and the risk factors associated with her vulnerabilities.

Children and Domestic Abuse – It is clear from the data revealed from agencies and from talking with Alicia's family that she dearly loved all her children, and she did her best in difficult circumstances to keep them safe. Children and young people are often unseen and unheard within domestic abuse cases and the review revealed that on the whole Simon's behaviour was addressed well by agencies, but this was not the case when Mark began his campaign of stalking against Alicia. The deterioration in Alicia's mental health was significant during the last year in her life and there was little triangulation to link Mark's stalking of her and her subsequent ability to care for the children. The impact of stalking must be understood in the context of trauma responses – stalkers infiltrate a victim's whole life and the impact on their ability to function, including when parenting will naturally be impacted. Alicia repeatedly told agencies she was scared of Mark, she fled to a refuge, and she took her 3 youngest children with her – of course the children would be scared too and the upheaval in their lives because of Mark's behaviour was undeniable.

Suicide Domestic Abuse and Stalking – The links between the increased risk of suicide in victims of domestic abuse is better understood at the point of writing the review which is over 3 years after Alicia's tragic death. Alicia's experience provides a stark reminder of the importance of prioritising the risk of suicide in victims of domestic abuse and stalking. This risk was particularly relevant when taken in the following context:

- Alicia's Adverse Childhood Experiences
- Alicia's existing mental health diagnosis
- The long-term abuse Alicia had been subjected to by two separate partners
- Alicia's two older children already being in care and coping with three young children at home – one of whom had significant care needs

- The degradation Mark used in his stalking campaign against Alicia, including public claims of Alicia being a sexual offender of children
- Alicia having to resign from her job because of Mark's stalking
- Alicia's experience of the criminal justice system
- Alicia's fear of not getting her youngest three children back after she was sectioned for a mental health crisis

Alicia told professionals intermittently she felt suicidal throughout the timeline period, most notably ten days prior to her death. The reality is that professionals did not take seriously the credibility of Alicia's threats of suicide or understand the context and background of the increased risk of her vulnerability in this regard.

The impact of COVID19 on Victims of Domestic Abuse – The impact of COVID19 is beginning to be understood by professionals but the long-term consequences are still revealing themselves. During lockdown Alicia was coping with three young children at home, and she was very nervous about sending child 3 to school because of the virus. Although social care did support her through these anxieties and offered extra help, Alicia ultimately had to cope at home on her own with her children. At the same time Mark continued his campaign of stalking against her, and we know for victims of stalking the pandemic heightened their fears[77] and mental health outcomes. The delays in the criminal justice system during the pandemic had significant impact on victims and Alicia's experience meant she was not here to see Mark convicted of stalking her as the court case was heard after her death. The panel note that the delays in the CJS created by the pandemic for victims of stalking and domestic abuse continue to this day.

Family Voice

The family were able to provide the chair with their observations after reading the review and the final thoughts will be reserved for them:

Alicia's dad:

Alicia's dad noted the significant impact Mark's stalking had on her and the children. He remembered the postponed harassment case due to COVID19, which resulted in a delay from charge to court of over a year, had *"a really big impact"* on Alicia's wellbeing and ultimately, she was not alive to see justice being served. He also commented on the fact that having to resign from her job due to Marks stalking was very distressing for Alicia. Her dad noted that she *"loved her job"* and *"was really good at it."*

After digesting the full review Alicia's dad made some clear observations which are important to record in full:

[77] https://www.paladinservice.co.uk/

> "I can't understand why Alicia was only ever offered civil injunctions and Mark wasn't arrested and pursued more robustly. I was also really shocked to read that Alicia was listed as 'any other business' on the MARAC list, she was a victim and was treated like an afterthought.
>
> I also wonder if Alicia was ever assessed for PTSD; many women who are diagnosed with PTSD look like they won't engage with services, but that is because they have been let down and have experienced violence and abuse so it could be trauma related rather than personality related. The trauma she experienced especially from the stalking impacted everything in her life and her kids were also badly impacted – it's a lifetime of generational trauma for them."

Alicia's sibling:

Alicia's sibling was kind enough to contribute to the review and gave the following observations and thoughts:

> "More could have been done to support Alicia with her mental health issues; I even phoned up myself with regards to her safety and ability to look after the children with a decline in her mental health. This was only a couple of weeks before my sister's death, they asked is she a danger right now? I said no but she could be.
>
> I think lot of abuse happened without my knowledge and my sister didn't want me to find out…I believe the constant stalking and bothering of my sister did and would impact my sister's well-being and mental health. I did see my sister's mental health deteriorating over the years, and I would visit my sister about 2 or 3 times a year.
>
> I believe my sister could have been helped more from the government or agencies even when I phoned up…there was nothing they could do I would have thought preventive measures would be than letting things getting out of hand."

The above observations provided the panel with the much-needed focus to develop recommendations. Alicia's dad was also involved in the development of these recommendations.

1.8 Recommendations

Single Agency Recommendations

All single agency recommendations were accepted by the panel and are reflected in the action plan (section 16 overview report). Given the time delay on the review, all single

agency recommendations were completed before the second author was commissioned.

Multi-Agency Recommendations:

The delay in this review has resulted in other DHRs addressing many of the recommendations needed for children as victims of DA. The panel were therefore satisfied that the learning needed to address the issues that arose for children within this review are already underway within Somerset and significant changes have already been implemented.

The panel agreed on the following multi-agency recommendations:

- Raise awareness of risk escalation and identification in stalking and DA cases – via MARAC rep training
- Incorporate learning DHR045 and this DHR for professionals to gain insight into the connection between domestic abuse/stalking and the risk of suicide.
- Public awareness campaign during National Stalking Awareness Week – to include promotion of independent specialist stalking services that can support victims to explore legal and emotional support options.
- Feedback to family regarding progress of recommendations.

National recommendations:

- Highlight links between DA/Stalking and risk of suicide with DA commissioner for England and Wales.
- Send the published review to The National Stalking Consortium to highlight the need for research into risk for children in stalking cases including but not ltd to assessing access to children from the stalker via child contact.
- Send the published DHR to the Legal Services Consumer Panel[78] using Alicia's story to highlight the need for victims of DA to understand their rights and access to legal aid.

[78] https://www.legalservicesconsumerpanel.org.uk/

Appendix a – Action Plan

Please be aware this is a working document and subject to change

Single Agency Recommendations/Action Plan

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
Public Health Nursing (PHN) service to ensure that records are requested for all families with pre-school children known to have moved into Somerset.	Local	Audit records of UPP families known to have moved into Somerset. Summaries of previous concerns and actions together with Family Health Needs Assessment should inform onward care.	Public Health Nursing	N/A	N/A	Completed
To record all incidents of domestic abuse, regardless of how insignificant they appear	Local	Professionals to be reminded to record all incidents and review chronologies. Chronologies - in families where there is domestic abuse, even the most insignificant incident can help understanding of what is going on and can identify patterns and gaps.	CSC	N/A	N/A	Completed
All incidents should be analysed using **S**ituation, **B**ackground **A**ssessment **R**ecommendation tool	Local	Audit records. To inform actions required by Public Health Nurse practitioner.	PHN	N/A	N/A	Completed
For all families classified as Universal Partnership Plus child health reviews should be completed by a Public Health Nurse.	Local	Review current practice against standard operating procedures. Specialist skills required for in depth assessment	PHN	N/A	N/A	Completed
Pathway for people with Borderline Personality Disorder	Local	Mental Health Services to develop pathway	Mental Health	N/A	N/A	Completed

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
		Training to appropriate services. To recognise and understand behaviours of adults diagnosed with BPD which in turn will inform requisite action.	(And all appropriate services)			
When a patient attends the GP with evidence of bruising or an injury GP to show professional curiosity.	Local	Health Module has been developed as part of Domestic Abuse Training by SSP, in line with previous DARDRs Webinar to be created by SAR subgroup learning and development based on professional curiosity and promoted through Primary Care. Actual bruises observed by the GP should be addressed with sensitive conversation.	ICB, SSP working with SSAB	N/A	N/A	Completed
Remind MIU's about the domestic abuse referral pathway and Policy	Local	Via safeguarding supervision and memo to Service Managers. Refresh staff awareness of DA process & policy	SFT Named professional safeguarding adults / domestic abuse coordinator	N/A	N/A	Completed
For HTT's and CMHS to be reminded of the importance of chronological information in risk assessment and how coexisting stressors can impact on an individual's capacity to cope.	Local	Raise via safeguarding supervision and memo to service managers. To review clinical risk management training To ensure holistic risk assessment	SFT Named professional safeguarding adults	N/A	N/A	Completed
PIU admission checklist and discharge checklist to include professional curiosity on	Local	To review and update PIU admission checklist and discharge checklist	SFT Named professional	N/A	N/A	Completed

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
admission, and risk assessment on discharge to include consideration of domestic abuse.		As a means to start to embed domestic abuse routine enquiry	safeguarding adults			
To produce and circulate a 7-minute briefing document outlining the concept of confirmation bias.	Local	To write 7-minute briefing To raise awareness across SomFT of the concept of confirmation bias	SFT Named professional safeguarding adults	N/A	N/A	Completed
Staff training on Outcome Star	Local	Training to be developed and delivered to all Paragon staff To highlight importance of addressing all areas where support needs are identified	YOU Trust Paragon Manager	N/A	N/A	Completed
Training on importance of reviewing all referral information prior to appointment with a client and that DASH's completed by other agencies are reviewed.	Local	Training to be developed and delivered to all Paragon staff. To ensure that all risks are identified and actions are put in place to reduce risks	YOU Trust Paragon Manager	N/A	N/A	Completed
MARM Meetings to be considered for cases whereby usual support channels are not proving effective.	Local	Reminders for Managers to consider MARMMs during case management or MARACs MARAC does not achieve required outcomes for all cases and other routes need to be considered	YOU Trust Paragon Manager	N/A	N/A	Completed

Multi-Agency Action Plan

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion date and outcome
Raise awareness of risk escalation and identification in stalking and DA cases – via MARAC rep training	Local	Share review with MARAC reps via training and raise this as a case study for learning. Highlight stalking as a high-risk factor in DA cases, both in terms of risk of harm and of suicide	CSP	Develop training Deliver training	June 2025	Completed
Incorporate learning DHR045 and this DARDR for professionals to gain insight into the connection between domestic abuse/stalking and the risk of suicide	Local	Design a 7-minute briefing with links to Agenda Alliance and Learning Legacies included. Raise profile of work on links between DA and suicide, and include stalking as a risk factor in potential suicide.	CSP	Review both reports and develop learning briefing Disseminate via newsletters and other briefings with local statutory partnerships	April 2025	Completed
Promotion of independent specialist stalking services that can support victims of stalking to explore legal and emotional support options	Local	Public awareness campaign during National Stalking Awareness Week – April 2024. Empower victims of stalking to seek independent support and explore all their options.	CSP	Develop campaign materials Develop promotional strategy	April 2025	Completed
Feedback to family regarding progress of recommendations	Local	Feedback on recommendation action plan – 1 year after publication of review Ensure victims family are kept informed of the continued learning from the review	CSP	Feedback to family	1 year after publication of review	November 2026

National Recommendations

Recommendation	Scope of recommendation i.e. local or national	Action	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of Completion
Highlight links between DA/Stalking and risk of suicide with DA commissioner for England and Wales.	National	Flag review with DA commissioner's office on publication Raise the profile of the links to DA / Stalking and suicide.	CSP	Write and send letter to DA Commissioner for England and Wales	On publication	November 2025
Send the published review to The National Stalking Consortium to highlight the need for research into risk for children in stalking cases including but not ltd to assessing access to children from the stalker via child contact.	National	Send published review to national stalking consortium to suggest a focus on the impact of stalking on children and young people during national stalking awareness week.	CSP	Send review highlighting the recommendation to National Stalking Consortium – Suzy Lamplugh Trust	On publication	November 2025
Send the published DHR to the Legal Services Consumer Panel[79] using Alicia's story to highlight the need for victims of DA to understand their rights and access to legal aid.	National	Send published review to Legal Services Consumer Panel	CSP	Send review highlighting the recommendation to CEO at Legal Services Consumer Panel.	On publication	November 2025

[79] https://www.legalservicesconsumerpanel.org.uk/

Appendix B – Home Office Quality Assurance Feedback Letter

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Heidi Hill
Project Change & Improvement Officer
Somerset Council
County Hall, The Crescent
Taunton
TA1 4DY

29th October 2025

Dear Heidi,

Thank you for submitting the Domestic Homicide Review (DHR) report (Alicia) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 30th September 2025. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

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

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

The DHR report including the executive summary and action plan

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

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

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

Yours sincerely,

Home Office DHR Quality Assurance Board

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Alicia
COMMUNITY SAFETY PARTNERSHIP	Somerset
DATE REVIEWED BY QA BOARD	30th September 2025
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• The report includes a moving tribute to Alicia from her father. • It is helpful to see that additional learning from this case has been addressed in other reviews undertaken in Somerset. • The Chair undertakes a very good analysis of the stalking Alicia endured and the lack of appropriate response from the police and other agencies. • The report helpfully highlights that there was strong multi-agency working between the police and external services, including domestic abuse and mental health teams and that the GP practice demonstrated excellent record-keeping and effective referrals to specialist services. • The decision to produce a draft report outlining the analysis and recommendations for discussion with panel members ahead of reconvening is commendable. This approach helped avoid further delays for both the coroner and the family.
FEEDBACK FOR FUTURE DHRs	

	DHR SECTION	**DHR QA BOARD FEEDBACK (improvements required before publication)**
	Title Page	No amendments required.
1	Contents Page	No amendments required.
2	Pen Portrait	No amendments required.

3	Condolences	No amendments required.
4	Confidentiality and Anonymity	No amendments required.
5	Terms of Reference	No amendments required.
6	Equality and Diversity	No amendments required.
7	Background Information	No amendments required.
8	Combined Chronology	No amendments required.
9	Overview	Please continue to use the term "DHR" (Domestic Homicide Review) for the time being, as the legislation introducing the term "DARDR" (Domestic Abuse Related Death Review) has not yet been commenced.
10	Analysis	Alicia's childhood adversity was not linked to her current mental health, which would have been a valuable consideration. Please consider including some additional analysis on this.
11	Conclusions	No amendments required.
12	Lessons learnt and recommendations	Not all issues identified in the analysis are addressed by the recommendations. The QA Board felt that two additional national recommendations on legal aid and child contact could have been included and/or considered.
13	Timescales	No amendments required.
14	Involvement of family / friends / community	No amendments required.
16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.
18	DHR Author	No amendments required.
19	Parallel Reviews	The outcome of the inquest should be included in the report.

20	Dissemination	No amendments required.
21	Action Plan	The action plan in the appendices outlines future recommendations for single agencies in a table format, ensuring they are specific, measurable, achievable, realistic and timely. However, there is currently no accountability framework for multi-agency recommendations, which should be added.
22	Has there been a request to withhold publication? *If Yes, include the reason for the request. Is it proportionate and appropriate?*	No requests to withhold publication.
23	Any other comments	• Overview report: chronology, page 19 – the QA Board suggest rephrasing this to emphasise that Alicia's progress was hindered by Mark's behaviour, not driven solely by her actions. • In April 2020, the report sets out that Mark falsely accused Alicia of impersonating a social worker. No action was taken. Alicia later reported Mark for making false allegations to her workplace and Children's Social Care. Police responded with only 'words of advice'. This should be highlighted as poor practice. • The report would benefit from numbered paragraphs and a thorough proofread for typos.