Domestic Homicide Review

Into the death of Jessica in March 2024

Overview Report

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Family tribute

Whilst there's no denying the struggles mum went through; she was never afraid to let it be known that she could overcome them. She was always close to us, telling us her stories both the good and bad, how she was determined to lead a happy life and be there to see her grandkids. She was filled with so much life despite all the events that knocked her down.

She absolutely loved nature and science, how the two worked together to create so many natural wonders. We didn't grow up well off; we lived in council houses and on benefits, but that never stopped mum from trying to give us a beautiful life. She knew we deserved the world, and she wouldn't let us grow up without seeing it. Endless trips to beaches, watching lunar and astral events, trips to the Isle of White, Dover and the Jurassic coast to look for fossils (which she loved, and I still have a small collection of hers today).

Mum made sure that we never felt cheated out of an exciting childhood, that we always had stories to tell our friends when we came back from summer break. Us kids were truly her driving force to keep going; nothing could have wavered her love for us, and she knew as long as she had us, she could do anything. It was only after she began to feel like she was losing us that she slipped into a very vulnerable state.

My brother had moved away briefly for a job, and I was living with a partner. Alongside the isolation of Covid at the time, she became increasingly vulnerable. We moved back and tried to help her get the care she needed. Things were going better; she finally had a secure house after losing the last to a fire. She was going to get the carpet done and remodel the 2nd bedroom into a games/spare bedroom so we could come visit her more. I would visit her frequently; we would sit and chat or take the family dog on a walk.

Our dog was like a daughter to her; if she hadn't loved us so much, I might've believed she loved her more at times! Having a dog companion gave her a level of freedom she didn't always have on her own. As she became more vulnerable, she became increasingly anxious and paranoid. Her dog really helped ease her anxieties when being home alone and leaving the house, so even if we couldn't get to her that day, she always had her by her side. She really improved throughout the year of 2023; she was getting various help, taking medications and was less paranoid.

However, despite all that, visiting mum suddenly became much harder towards the end of 2023, as she began getting close to this "partner" of hers. She expressed how he would be violent and vocal towards her, how he was homophobic and transphobic, blamed her for our identities and threatened to harm us if he ever saw us. Of course, mum chose to protect us but unfortunately was in too vulnerable a position to fully escape his clutches. She didn't want to be alone; there's only so much a dog and visits from your kids can do which were only dwindling as he isolated her more.

When she would try to leave, he would always find his way back and be even more dangerous than before. Thus, she began pushing us kids away for our sake. She kept in contact, but we

could no longer show up unannounced because she didn't want him to be there and hurt us. She was changing numbers more frequently than before and quickly started to become increasingly paranoid, not only towards large groups coming for her but also towards us. She expressed a lot of fear, even to police, about how friends of her partner were threatening her or how if she had him arrested, they would come and kill her themselves. Her partner was isolating her and feeding her lies and new beliefs that were never expressed before she met him. Being vulnerable, she was much more likely to believe that he could bring real harm to her or us kids.

We believe the system failed her in so many ways. The police were aware of his abusive behaviour, NHS aware of her mental health issues, and both collectively knew of her paranoia and suicidal tendencies, especially towards the end. I genuinely believe so much more could have been done, that she could have been offered a better escape from this boyfriend beyond threatening to arrest him (as many know, that often goes nowhere as the victims are rarely believed or not enough is done to prevent harmful backlash). Could we as family not have been contacted when she was found trying to end her life days before she actually did? Our mum fought so hard to be here, to build a life into which she could welcome her grandchildren. But because services failed her so severely in those final months, that will now never happen. She'll never get to see us grow up, celebrate our accomplishments, or have families of our own. Not only are we having to grow up without our mum, we have to come to terms with the fact that our mum's dream will never be realised, knowing our own future children will never get to meet her. She was the strongest person we will ever know, and she deserved better.

The Review Panel wishes to express its sincere condolences to the family of Jessica

Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ABH	Actual Bodily Harm
AMHP	Approved Mental Health Practitioner
ATR	Alcohol Treatment Requirement
CAMEO	A specialist psychosis service
DAIS	Domestic Abuse Induced Suicide
DARA	Domestic Abuse Risk Assessment
DARDR	Domestic Abuse Related Death Review
DASH	Domestic Abuse, Stalking, Harassment and Honour-Based Violence Risk Assessment
DASV	Domestic Abuse and Sexual Violence
DSVA	Domestic and Sexual Violence and Abuse
DHR	Domestic Homicide Review
DRR	Drug Rehabilitation Requirement
ED	Emergency Department
HMPPS	His Majesty's Prison & Probation Service
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Report
ISA	Information Sharing Agreement
JSNA	Joint Strategic Needs Assessment
MARAC	Multi-Agency Risk Assessment Conference
MARM	Multi-Agency Risk Management
MASH	Multi-Agency Safeguarding Hub
MEAM	Making Every Adult Matter
NFA	No Further Action
NRM	National Referral Mechanism
OCD	Obsessive Compulsive Behaviour
PTSD	Post-Traumatic Stress Disorder
REDS	Relational Emotional Difficulties Service
SAM	Stalking Assessment and Management
SARA	Spousal Assault Risk Assessment
S136	Section 136 of the Mental Health Act 1983 gives police emergency powers to detain someone in a public place if they appear to be suffering from a mental disorder and need immediate care or control, for the safety of themselves or others.

1. Introduction

i. This Domestic Homicide Review (DHR) examines agency responses and support given to Jessica, a resident of Cambridgeshire, prior to her death in March 2024. On that day, Jessica's neighbour alerted the police that they had not seen her for some days and could hear her dog within her property. The police gained entry and found that she had died by suicide.

ii. The review examined the involvement that organisations had with Jessica, a White British woman in her 40s and Krzysztof, a White Polish man who was, at the time of Jessica's death, in his mid-thirties, between 1st January 2022 and March 2024.

iii. The key reasons for conducting a DHR are to:

- establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims.
- identify clearly what those lessons are both within and between organisations, how and within what timescales they will be acted on, and what is expected to change.
- apply these lessons to service responses including changes to policies and procedures as appropriate; and
- prevent domestic violence and abuse and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working.
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

iv. This review began in March 2024, following a decision by Cambridge Community Safety Partnership to conduct a DHR. A notification of a possible review was received by the partnership from Cambridgeshire Police, and, following core group research and discussions, it was confirmed that the case met the criteria for conducting a DHR in accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004. That decision was ratified by the Chair of the Cambridge Community Safety Partnership, and the Home Office was notified in March 2024.

v. In February 2024, the Home Office issued notice that in future Domestic Homicide Reviews would be called Domestic Abuse Related Death Reviews (DARDR) in recognition that not all victims die because of homicide but rather in the context of domestic abuse. Although Jessica's death occurred before this change, the panel decided to adopt this naming convention considering the circumstances of her death. Consequently, the acronym DARDR is adopted for the remainder of the report.

2. Confidentiality

i. The findings of this DARDR are confidential. During the review, information was available only to participating officers/professionals and their line managers; it remained so until it had been approved by the Home Office Quality Assurance Panel and published.

ii. Dissemination is addressed in Section 11. Publication below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Jessica's family. Pseudonyms were not used for the DARDR panel members.

iii. Details of the deceased and her partner at the time of her death:

Name (Pseudonym)	Gender	Age at time of death	Relationship to deceased	Ethnicity
Jessica	Female	MID-40s		White British
Krzysztof	Male	MID-30s	Alleged perpetrator	White Polish

iv. Family members have been referred to by relationship only rather than by name to protect their identities and details have been obscured or left out where immaterial to provide further protection.

3. Timescales

This review began in March 2024 and was concluded in October 2025. The Home Office recommends that reports take six months to complete. It was not possible to complete this review within that timescale as:

- The review chair was appointed in July 2024. As this came at the start of the summer break, two months elapsed between the appointment and the first panel meeting.

- Time was given for the engagement and comfort of Jessica's children to be involved in the review, including extended time to read the draft overview report. The panel acknowledged that it was important to them that any published report acknowledged Jessica's story beyond the final two years of her life, and that engaging with the process during a period of such grief was challenging.

- Jessica's inquest did not take place until August 2025; consequently, finalising the report was delayed until after this process took place.

4. Methodology

i. The purposes of a review were addressed to establish whether any agencies have identified possible and/or actual domestic abuse that may have been relevant to the death of Jessica. If such abuse took place and was not identified, the review aim was to consider why not, and how such abuse can be identified in future situations.

ii. If domestic abuse was identified, the review aimed to focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. Where domestic abuse was identified, the review examined the method used to identify risk and the action plan put in place to reduce that risk. The review also considered current legislation and good practice. The review examined how the pattern of domestic abuse was recorded and what information was shared with other agencies.

iii. The analysis on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Jessica and Krzysztof. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template. In addition to IMRs, five organisations provided Summary Reports as they had had limited involvement with either party.

iv. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the panel. Neither the IMR Authors nor the Senior Managers had any involvement with Jessica or Krzysztof or the staff that did during the period covered by the review. The IMRs attended to key lines of enquiry which are set out below.

v. The panel met to analyse the submitted reports and contextualise them within best practice and academic research, with a view to identifying lessons to be learned and recommendations for improvements. The key lines of enquiry were summarised into themed headings to frame the analysis.

5. Terms of Reference

The Review Panel first met in September 2024 to consider draft Terms of Reference, the scope of the DARDR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report.

Key lines of enquiry:

i. Were practitioners sensitive to the needs of Jessica and Krzysztof, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of

training and knowledge, to fulfil these expectations? Did staff engage with available training?

ii. Did the agencies have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) or other risk management tools, conduct risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Jessica and Krzysztof? Did the agencies have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Were Jessica and Krzysztof subject to a MARAC or other multi-agency forums?

iii. Did the agencies comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this situation? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided to Jessica, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were Jessica's wishes and feelings ascertained and considered? Is it reasonable to assume that her wishes should have been known? Was she informed of options/choices to make informed decisions? Was she signposted to other agencies?

vii. Had Jessica disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared where appropriate?

viii. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of Jessica or Krzysztof and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics or intersecting factors relevant in this case?

ix. Were senior managers or other agencies and professionals involved at the appropriate points?

x. Are there lessons to be learned from this case relating to the ways in which agencies worked to safeguard Jessica and promote her welfare, or the way they identified, assessed and managed the risks posed by Krzysztof? Was there an appropriate level of joint working between agencies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xii. How accessible were the services to Jessica?

xiii. Were links between mental health, substance misuse and domestic abuse identified during any assessments or contacts with either individual?

xiv. Were there any key vulnerability episodes in relation to Jessica's mental health, substance misuse or other domestic abuse before the scope of the review that could have afforded an opportunity for interventions that might have made Jessica's future safer?

6. Involvement of family members and friends

i. Jessica had a previous marriage, outside the scope of the review, and three children. Her former husband was contacted by the Chair of the review, having been identified as a family member by the police. The Chair spoke to him by telephone, and he supported the process but chose not to have any further involvement. The police also identified that Jessica had a brother and enquiries were made to identify him, but these were not successful.

ii. As two of Jessica's children were adults, the Chair wrote to them separately and they chose to be involved in the review. They were supplied with the Home Office and AAFDA leaflets and were advised of a suicide bereavement service which they were already aware of. They agreed to an AAFDA referral for advocacy through the review and were supported by this advocate throughout the process.

iii. Both were offered the opportunity to meet with the panel, declining this but supplying images and a short video for the panel to view. The children remained involved by correspondence, supplying the opening tribute and insight into the nature of Jessica and Krzysztof's relationship which led the panel to have a better understanding of how Jessica's abuse was not identified by agencies.

iv. The report was discussed with one of Jessica's children as it was completed. It was shared electronically and by post for any final comments that they wished to make prior to Home Office submission.

7. Contributing organisations

15 organisations were approached for information as part of the review with 13 responding that they had contact with either/ or Jessica and Krzysztof. Those that had contact were asked to supply further information as follows:

Agency/ Contributor	**Nature of Contribution**
Cambridgeshire Police	IMR
Cambridge University Hospital Trust	IMR
Cambridge Access GP Surgery	IMR
Cambridge Partnership Foundation Trust	IMR
Adult Social Care	Short Report
Children's Social Care	Short Report
<u>Cambridge City Council:</u> Customer Services Housing Services Housing Advice Services Environmental and Public Health Harm Reduction and ASB	Short Report
Department of Work and Pensions	Short Report
Change Grow Live (CGL)	IMR
Cambridge & Peterborough IDVA Service	Short Report
Probation Service	IMR

8. Review panel members

i. The Review Panel was made up of an Independent Chairperson and senior representatives of organisations that had relevant contact with Jessica and Krzysztof. It also included a senior member of the Cambridge Community Safety Team and an independent advisor from a domestic abuse service.

ii. A panel member was requested from the Public Health Team to advise on the Suicide Prevention Strategy. Unfortunately, due to a role transition there was no adviser available. Advice and support with the writing process was given by the Public Health Team by email correspondence with the review chair. These communications were discussed by the panel.

iii. The panel consisted of senior professionals and met on three occasions during the review with a final report confirmation taking place by email correspondence.

Agency	**Name**	**Job Title**
Aletheia Reviews	Deborah Cartwright	Independent Chair & Author
Aletheia Reviews	Loukia Michael	Co-Author
Cambridgeshire DASV Partnership	Vickie Crompton succeeded by, Sarah Fines	DASV Partnership Manager DA Review Coordinator
Cambridgeshire Police	Jim Donington	Detective Inspector
Children's Social Care	Liz Clarke	Service Director for Quality Assurance and Practice Improvement for Children's Services in Cambridgeshire
Cambridge University Hospital Trust	Tracy Brown – succeeded by Jenny Harris	Adult Safeguarding Lead Head of Safeguarding
Integrated Care Board	Jenny Thompson	Designated Nurse for Safeguarding Adults
Cambridge Community	Keryn Jalli	Strategic Resettlement and Community Equity Lead

Safety Partnership		
Cambridgeshire and Peterborough IDVA service	Annette Chandler	Senior IDVA
Probation	Helen Whitley	Deputy Head of Cambridgeshire and Peterborough PDU
Adult Social Care	Julie Rivett	Service Manager & Strategic Lead
IMPAKT Housing & Support	Laura Plava succeeded by Sarah Cowen	Head of Domestic Abuse Services
Cambridgeshire & Peterborough Foundation Trust	Rachel Roberston/Linda Coultrop	Advanced Practitioner Safeguarding: Domestic Abuse
Cambridgeshire & Peterborough Foundation Trust	Jayne Fox Attended one meeting in place of the above	Named Nurse Safeguarding Children
Change Grow Live (CGL)	Aimee Elener	Quality Lead

9. Independent chair and report author

i. The independent chair and report author for this review is Deborah Cartwright. Deborah has worked in the social sector for over 30 years, with experience in learning disabilities, mental health and domestic abuse gained from roles ranging from frontline practice to executive leadership. The expanse of this career has allowed for the development of a broad knowledge and

understanding of the multi-agency landscape in the social and public sectors, including many years of participation in a range of statutory review processes.

ii. Deborah has developed a wide range of skills and techniques around the analysis of complex data, report writing, consultation, evaluation and learning review of practice systems. She undertook a research-based master's degree, graduating with distinction and has qualified with AAFDA as a Home Office accredited DHR/DARDR Chair. Deborah has not practised in Cambridgeshire and is fully independent.

iii. The Co-Author of this review is Loukia Michael who has worked in the domestic abuse sector for 17 years in roles encompassing research, writing, communications, business development and project development and is a Home Office-accredited and qualified DHR/DARDR Chair.

10. Other reviews/ investigations

i. There were no parallel reviews into Jessica's death.

iv. The coroner was notified of the review in September 2024 and requested information from the panel to inform the work of the inquest. The inquest was held in August 2025 with the coroner finding the cause of death to be by suicide.

11. Publication

The actions from this report are overseen by the DASV Partnership at Cambridgeshire County Council and this overview report will be published by Cambridgeshire in the following ways:

i. It will be posted on the Cambridgeshire Community Safety website for access by all agencies and members of the public.

ii. Family members will be offered copies of the report and website addresses.

iii. Further dissemination of the learning will be via:

a. The Cambridgeshire DASV Strategic Board.
b. The Cambridgeshire Safeguarding Adult's Board.
c. The Cambridgeshire Safeguarding Children's Board.
d. Additional agencies and professionals will be identified who would benefit from having the learning shared with them.
e. Review findings will be included in a lessons learned webinar as part of the 16 days of action.
f. The Domestic Abuse Commissioner's Office
g. The Office of the Police and Crime Commissioner for Cambridgeshire and Peterborough.

12. Equality & diversity

The panel considered the nine protected characteristics (age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, ethnicity, sex and sexual orientation) as prescribed in the Equality Act, 2010, seeking to establish if they were relevant to any aspect of this review. The panel also took an intersectional perspective in considering Jessica's access to services, specifically in relation to the multiple disadvantages that she experienced. The panel considered whether access to services or the delivery of services were impacted by any of these features, and if any of them had in any way acted as a barrier to her help-seeking.

12.1 Sex

i. There is extensive research to support that in the context of domestic violence and abuse, females are at greater risk of being victimised and significantly harmed or dying because of this abuse. In fact, the term 'femicide' was coined in the 1970s in recognition of the extent of these violent deaths of women.[1]

[1] South African feminist activist and scholar Diana Russell popularised the term to help rally activists to protect women. Russell's definition has since been refined to include only intimate partner crimes.

ii. Violence against women remains devastatingly pervasive with one in three women internationally subjected to physical and/ or sexual violence by an intimate/ non-intimate (in many instances of sexual violence) partner.[2] Physical and/ or sexual violence is the leading cause of injury for women globally.[3] The health consequences of this violence are far-reaching including physical injuries, chronic pain, gastrointestinal issues and increased risks of depression, anxiety and suicide attempts.[4]

iii. The fourth annual report from the national Domestic Homicide Project which works across England and Wales was published in March 2025. This report identified that, in line with wider literature on domestic homicide and suicide following domestic abuse, most victims were female (73%).[5]

iv. Suicide in the context of domestic abuse has been recognised as a national issue and, consequently, reviews are now undertaken for these deaths as well as homicides.

v. Based on the information provided by agencies and by Jessica's family, she was subject to violence and coercive control in her final relationship during a period of significant vulnerability. There were (based on her family's insights) question marks regarding her own expression of wider fear and abuse from her community. Jessica expressed her fear and she shared experiences that might have been 'red flags' for agencies. Like many other women experiencing multiple disadvantages, harms to her may have been hidden from view in the context of her mental health and substance use needs.

vi. Consequently, services did not identify her at being of high risk of harm, rather her needs were addressed on an episodic and siloed basis. This left Jessica

[2] World Health Organisation, 2021.
[3] Un Women UK (accessed 15.5.25)
[4] Violence Against Women – Key Facts, World Health Organisation [Accessed 15.5.25]
[5] Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides 2020-2023 Year 4 Report, Published March 2025

without a professional who explored and gained coherence regarding the reality of her situation.

12.2 Disability

i. Individuals are disabled under the Equality Act, 2010 if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. Jessica experienced persistent mental health issues throughout the final two years of her life which qualify as "substantial, adverse, and long-term".[6] Her mental health issues were compounded/ exacerbated by substance use, but it was the view of the panel that the trauma and grief that she had experienced should be the primary consideration for her later suffering.

ii. Based on the information available to the panel, Jessica experienced grief at the loss of one of her children from which she never recovered. Although not diagnosed formally, it is likely that she experienced what is known as complicated grief, also known as prolonged grief disorder, a persistent and debilitating form of grief that can develop after the loss of a loved one. It is characterised by intense and prolonged grief reactions that significantly interfere with daily life and functioning, often lasting longer than 12 months.[7]

iii. Jessica spoke to agencies about the loss of her child consistently in the period within scope; it clearly continued to have a profound impact on her over many years. It was the panel's view that this was likely a causal factor on her dependence on pain-relieving/ opiate drugs. A combination of substance use, poor mental health, housing and homelessness issues and interpersonal violence speaks to a very high level of disadvantage in Jessica's life.[8]

[6] Equality Act, 2010
[7] Complicated grief, Mayo Clinic [Accessed 11.7.25]
[8] Gender Matters, 2020 – identifies that 3% of women experience this level of disadvantage.

iv. Jessica sought help at a time when the COVID pandemic interrupted the opportunity for face-to-face service provision, options were offered for online support or waiting. However, waiting, which Jessica chose, was contingent on the lockdown period being a one-off, which it wasn't. By the time the opportunity to attend to her issues came about she had already become seriously addicted to opiates.

v. Jessica's experiences speak to the need for early intervention in order to prevent a decline of this nature. Service accessibility during the pandemic meant that she was not able to access the support she wanted and needed at a time when the intervention may have changed the course of her life.

12.3 Intersectionality

i. Intersectionality is a sociological framework that assists in the analysis of how individuals' and groups' social and political identities result in unique combinations of privilege and discrimination. The nine protected characteristics, outlined above, contribute to this along with other factors, such as class, wealth and so on. Coined by Kimberle Crenshaw, the concept originated in considering the multiple and intersecting oppressions faced by Black women but is used today more broadly to consider power and oppression across society.[9]

ii. Intersectionality is an important concept when considering members of society who face multiple disadvantages and consequently experience more structural inequalities. Women who experience multiple disadvantages – in Jessica's situation this included poor mental health, addiction, socioeconomic inequality, and homelessness – are shown in research to be more likely to have experiences of abuse, violence and trauma. The co-

[9] Intersectionality 101: what is it and why is it important?

existence of these issues and experiences creates intersecting barriers to help-seeking and accessing service provision.[10]

iii. The panel observed that for Jessica this meant that services often worked with her presenting need, e.g. substance use, but not holistically across her experiences. This meant that the abuse she was experiencing remained largely hidden from view and that service settings became unsafe places for her, and it led to a reduction in her trust and belief that those services could help her.

12.4 Sexual orientation

i. Jessica disclosed on one occasion an issue in relation to her sexual orientation, stating to a police officer that she felt her neighbours were prejudiced towards her because of her bisexuality.

ii. There was no other mention of this throughout the case records, and there is no reason to believe that this caused any difficulties or barriers in her access to support.

iii. However, Jessica's children noted that their own identities were used prejudicially by Krzysztof to separate and isolate Jessica from her children. They identified that she managed the risk to her children by adapting to an isolated position in order to protect them from his violence and abuse. The use of identity is a tactic used by controlling perpetrators of abuse as they seek to isolate their victim. Often this is considered in the context of 'outing' someone for an LGBTQ+ identity.[11] However, protecting children from harm is also a common experience of women facing interpersonal violence.[12] It was the panel's view that these two issues intersected to isolate Jessica from her protective network.

[10] Hidden Hurt, Agenda Alliance. 2016
[11] LGBT Power and Control Wheel [Accessed 11.7.25]
[12] Children's Domestic Abuse Wheel [Accessed 11.7.25]

iv. This position meant that Jessica was isolated from the only people who knew what was happening to her. Given the known impact of interpersonal violence and abuse on women's mental health, the panel noted that Jessica's deterioration was exacerbated by a lack of awareness about her experience on the part of professionals.

13. Background Information

i. Jessica lived in Cambridgeshire, predominantly in urban areas although she was housed during a brief homeless period in more rural locations. She died by suicide in her own home.

ii. Jessica had left her family home (which she had shared with her husband and children) two years prior to her death. The couple had experienced the death of a child some years previously. Jessica did not recover from the grief of this loss. She became dependent on pharmaceutical opiates and then started to use heroin.

iii. Over the two years after her separation from her family, she tried to maintain a relationship with her children. Her substance use increased, and her mental health deteriorated. Her lifestyle became increasingly disadvantaged.

iv. She first formed a relationship with Krzysztof at CGL (Change, Grow, Live) where she was undergoing treatment for substance use. Jessica's children advised the panel that Krzysztof was abusive, violent and controlling. They described her fear of reprisal from him and said that, despite her attempts, she could not keep him away.

v. Jessica did share information about the relationship with professionals and was expressing fear of harm in her community. This was often considered in the context of drug-induced psychoses. However, one incident was

considered likely to be real, and she was offered services. By this point, however, her trust in agencies was minimal.

vi. Concerns were raised by Jessica's neighbour and Krzysztof after they had not seen her for a few days. When police entered her property, she was found deceased with the post-mortem identifying several lacerations to her arm as the likely cause of death. These were determined to be self-inflicted.

vii. The coroner's finding was death by suicide.

14. Chronology

i. Agencies supplied chronological information in relation to Jessica and Krzysztof's individual and relationship histories, from the 1st of January 2022 up to Jessica's death in March 2024. This information has been collated and set out below to show their interactions with service providers across the public, health and social systems. Some additional information from agency records and family recollections has been included to set the scene for the final period of Jessica's life.

Before the scoping period

2018

i. Jessica was married prior to the period under scope with one DASH[13] risk assessment (which was completed and assessed as standard) undertaken with the couple. No offences or complaints of domestic abuse were made. Police records note that advice was given and that the incidents were coded 'NFA' (No Further Action).

[13] Domestic Abuse, Stalking, Harassment and Honour-based violence risk assessment tool.

2019

i. In September 2019, Jessica's GP referred her to the secondary care mental health team at CPFT (Cambridgeshire and Peterborough Foundation Trust). The referral stated that although Jessica had previously declined the offer of group therapy, she now felt she was in the right place to consider it. Unfortunately, the practitioner was unable to make contact and so left a voice message encouraging her to call back and giving contact numbers in the event of a crisis. Further attempts by the practitioner over the next few days did result in contact but Jessica said that she was not able to talk at that time as she was going for a job interview. The practitioner suggested contacting her again in a few days' time which she agreed to. When the practitioner called on the agreed date, the call was not answered.

2020

i. Starting in March 2020 and lasting until July 2021, the UK experienced the COVID pandemic. This comprised two full lockdowns of society (March 2020 – June 2020 and January 2021 – July 2021), and a series of tiered restrictions in between. The pandemic meant that hospital services were working on contingency procedures to accommodate the influx of patients, and that all services during periods of lockdown had to introduce alternative ways of meeting clients/ patients.

ii. In February 2020, Jessica's GP made a second referral to secondary mental health services at CPFT, this time stating that Jessica had chronic anxiety and depression and that she (Jessica) believed that she had post-traumatic stress disorder (PTSD) following the death of her young son in 2004 from a heart condition. An appointment was offered for two weeks later.

iii. On the day of the appointment, Jessica telephoned to say that she had been in close contact with someone who had tested positive for Covid and that she herself had a fever. She was offered a phone assessment as an alternative but declined, saying she would prefer to see someone in person, so was given

another appointment in April. In April, due to Covid, the team was obliged to suspend face-to-face appointments, and a telephone service was implemented. When the practitioner called, Jessica reiterated that she wished to be seen in person and was happy to wait until such time as that could be facilitated.

iv. She confirmed to the practitioner that she had support at home, stating, *'All my kids are here, my husband is at home, so it's unlikely that I will do anything to myself. The PTSD is bad at the moment; it usually is bad this time of the year, but I have some meds from the GP and it's not like I'm going to do anything to myself so I will wait. Hope that's ok with you.'*

v. She was advised that this was okay if she was certain that she could wait and could keep herself safe. She was informed that her referral would therefore be closed and that she could ask her GP to re-refer her when appropriate. A safety plan was discussed; to contact her GP or FRS[14] (First Response Service) if she needed help in a crisis.

vi. In August 2020, the CPFT mental health services implemented video service in response to the government's Covid restrictions and their guidance on face-to-face appointments. Jessica's referral was reviewed, and she accepted an appointment for early August via a video link. In advance of this appointment, she was sent a PTSD questionnaire. Jessica returned the PTSD questionnaire two weeks after her scheduled appointment, which she did not attend.

vii. In the questionnaire Jessica described the impact of several traumatic life events, starting with two house fires when she was a child. She also described the death of her six-year-old son following a heart transplant, preceded by another house fire in which she had lost everything, including sentimental

[14] For mental health support

items. Jessica stated that both her parents had died of cancer. She said that she experienced nightmares, vomiting and palpitations on many days.

viii. As Jessica hadn't attended her appointment, she was sent information on how to get support with child bereavement, which was indicated on the referral, and information on how she could self-refer should she wish to discuss the PTSD questionnaire she had returned.

ix. By December 2020 Jessica and her husband had separated in a manner described by him in police records, following Jessica's death, as '*acrimonious'*.

2021

i. In October 2021, police were called to a report of a female in a vehicle who had been seen to inject herself and who had a large quantity of tablets next to her. The woman was confirmed to be Jessica, and she was detained for a search under Section 23 of MDA (Misuse of Drugs Act) 1971. This resulted in two used syringes containing traces of what appeared to be heroin being seized from the vehicle. The officers raised their concerns regarding Jessica's drug use, association with drug users, mental health and lack of support, which were recorded within a F102 (Adult Protection referral). The referral was submitted to the Multi-agency Safeguarding Hub (MASH) for sharing with other agencies via Adult Social Care (ASC) on a 'No Consent' basis.[15]

ii. Police records show three interactions within three days in the week before Christmas 2021, all involving a dispute with Jessica's neighbours who, Jessica reported, had threatened to kill her. Attending police officers were refused entry to Jessica's property but she spoke through the letterbox, stating that she was suffering from PTSD, depression and anxiety, conditions she felt were

[15] 'No consent' referrals take place where concerns about the individual supersede their right to consent to a referral, in this instance Jessica was considered vulnerable enough that the referral should take place irrespective of her consent.

exacerbated by the incidents with her neighbours. She said that she no longer felt safe to leave her home and that she could hear her neighbours talking about her when she was in her house.

iii. Jessica said that she felt targeted because the neighbours were discriminatory because she was bi-sexual. An Adult Protection referral was submitted to MASH.

Within the scoping period

2022

i. Just after Christmas, in the early days of 2022, a concern for safety was reported to the police by a caller from Sky Betting & Gaming as a result of a female threatening suicide if her money was not refunded. The woman, later identified as Jessica, had said that she had previously attempted suicide. No offences were identified, and the police records note that there was, therefore, no role for the police as the ambulance service was dealing with the incident. The panel has not seen any record that the ambulance service attended.

ii. At the end of January, following a public report of a female slumped over the steering wheel of her car and possibly in cardiac arrest, Jessica was found in possession of heroin. Paramedics in attendance described her as intoxicated. She is reported to have threatened to damage the car park barrier and to harm a bystander after he had smashed her car window to provide medical assistance. She was arrested and received a conditional caution with a requirement to engage and co-operate with substance misuse service CGL.

iii. CGL received the referral within 2 days but attempts to contact Jessica by telephone were unsuccessful. An email was sent to the police to request that they inform Jessica of a conditional caution appointment scheduled for mid-February.

iv. Within days, Jessica was found by police in possession of crack cocaine, and an involuntary interview was arranged. She stated that she was suicidal and had been depressed for a prolonged period following the death of her 6-year-old son in 2004. She said that she had not sought support from her GP because he was a neighbour and that she did not want him knowing about her problems and drug addiction. An Adult Protection referral was submitted to MASH and shared with the police Integrated Mental Health Team (IMHT) and CGL.

v. Jessica reported that she had stopped using heroin in December 2021. Since then, however, she had been found in possession of heroin on two occasions as well as of crack cocaine. She stated that she also used cannabis whilst taking her prescribed medication of Codeine and Diazepam.

vi. In early February, Jessica was charged with two counts of Possession of Class A drugs, (crack cocaine and heroin) and bailed to appear at Magistrates' Court in late September. She indicated her willingness to cease her drug use, and an Adult Protection referral was submitted to MASH. This was shared with IMHT, CGL and the Criminal Justice Liaison and Diversionary Service (LADS). MASH staff exercised their professional judgement, and *'consent was overridden in the belief there were current indicators of risk of harm to Jessica based upon her history and recent presentation'*. On this basis some referrals were made, but the referral was not shared with her GP due to specific consent being refused.

vii. CGL received the Adult Protection referral, and Jessica was offered her conditional caution appointment for a date in mid-March which she attended. She disclosed that she smoked heroin daily and cannabis *'not every day'*, and that she took pregabalin for back pain, anti-sickness medications, amitriptyline, Codeine and Diazepam. It was not stated whether these medications were GP-prescribed or illicit.

viii. At the appointment Jessica said that she was unsure if CGL *'was for her at the moment'* as she felt that she needed *'intensive therapy'* due to the effect on her mental health of the loss of her son. She reported that she had not received any bereavement counselling and support numbers for CRUSE bereavement service, SAMARITANS and 111 option 2[16], were provided.

ix. Jessica was provided with information detailing treatment and support available and was encouraged to consider engaging with CGL. An appointment for a comprehensive assessment was booked for a few days' time, but Jessica did not attend.

x. When CGL made contact by telephone, she stated that she was unable to attend as she was spending time with one of her sons who she had not seen in a long time. It was noted that she sounded as though she was becoming tearful. She asked to reschedule her appointment for a week's time, and this was agreed.

xi. An automated text message appointment reminder was sent, but Jessica did not attend the comprehensive assessment. In line with standard policy, two attempts were made to contact her by telephone but, as Jessica had not consented to voicemail, no message was left.

xii. At the end of March, Jessica attended CGL for a comprehensive assessment which included screening for blood borne viruses (BBV). She reported using heroin daily, mainly smoking and only occasionally intravenously due to not having *'much success'* with this route of admission historically and suffering from abscesses. She also disclosed having previously injected in her groin. She also reported using crack cocaine alongside heroin *'once every 6 weeks or so'* and smoking cannabis *'a few times a week'.* Opiate Substitute Treatment (OST) was discussed and Jessica stated that she would like to discuss this with a prescriber as her goal was to not use dependently.

xiii. At the appointment, Jessica said that she felt that her drug use was impacted by anxiety and depression as well as by significant bereavements. She stated that she would like to seek further support for her mental health but that her GP, although prescribing medication, would only offer group therapy as opposed to

[16] If someone requires urgent mental health support in the UK, they can call NHS 111 and select option 2. This option connects to trained mental health professionals who can provide immediate advice, support, and guidance. It's available 24/7 and is intended for those in distress or experiencing a mental health crisis.

her preferred option of one-to-one support. She reported ongoing feelings of suicide and suicidal ideation. Consent to speak to her GP was discussed and Jessica was advised that this was in order to share her treatment needs; she did not give this consent.

xiv. Jessica was provided with a Naloxone kit[17] and advised that she would be contacted with a clinical appointment to discuss Opiate Substitute Treatment. She also accessed the needle exchange and was provided with injecting paraphernalia and advised around safe injecting. Finally, she was offered an appointment for a few days' time at the 'welcome pod' where she would be advised of CGL's treatment pathways and what to expect from the service.

xv. Jessica did not attend the 'welcome pod' appointment, and, over the next few weeks, various attempts were made to contact her by telephone, text message and letter in line with standard practice, asking her to make contact with CGL.

xvi. In the meantime, Jessica did access the needle exchange where she described *'using for one final hurrah before getting clean'.* She was advised of safe limits and tolerance issues.[18] Jessica stated that she was not suicidal but mentioned that it was approaching the anniversary of her son's and father's deaths, and it was noted that she was tearful. She reported being unsure if she was ready to engage with CRUSE or any other bereavement or counselling services and said that one of her sons was aware of her substance use and was very supportive. Jessica confirmed that she was still in receipt of Naloxone and reported that she normally smoked heroin but that one of her friends would inject her this weekend. Jessica's recovery coordinator was advised that she had presented.

xvii. In mid-April, CGL contacted Jessica who stated that she was hoping to move accommodation. She disclosed that she had used heroin over the weekend but was now trying to smoke rather than inject. Jessica was advised that she would not be able to receive OST until she provided consent to liaise with her GP, was reassured that her GP would not see her engagement with CGL as a negative and encouraged to reconsider consent. Jessica said that she was not sure that she wanted OST as she was thinking about self-detoxing and cutting down. She asked if she could be prescribed medication for the side effects of opiate withdrawal but was advised that CGL would need to liaise with a GP to prescribe any medications in accordance with their safe prescribing policy. It was agreed

[17] A drug to potentially reverse the effects of an opiate overdose

[18] A person may develop tolerance to a medication or substance when used repeatedly. For instance, when morphine or alcohol is used for a long time, larger doses must be taken to produce the same effect. Inversely if a person reduces substance use, they are at higher risk of accidental overdose.

CGL would contact her the following week. Jessica was also advised of the results of her BBV screening (negative to Hepatitis B & C and HIV.)

xviii. A few days later, the police recorded an incident of harassment between Jessica and a neighbour, noting that disputes between Jessica and her neighbour had been escalating in frequency and severity since December. Jessica made allegations of neighbours climbing into her bedroom window and a neighbour alleged that Jessica had repeatedly threatened to set fire to their house. The neighbour expressed concerns for Jessica's deteriorating mental health. Jessica's housing provider tried to contact her because it was considering taking tenancy action.

xix. At the end of April 2022, CGL again attempted to reach Jessica by telephone but was unsuccessful.

xx. In May, Krzysztof was arrested for a domestic abuse related Common Assault upon his previous partner. A DASH was assessed as medium risk and a safeguarding referral was submitted to MASH in respect of their young daughter. As the victim did not want to support an investigation or make any formal complaint, and there was insufficient evidence to pursue an evidence-led prosecution, no further action was taken. It was noted that Krzysztof also had an extensive history for violence, drugs, and assaults (including on police).

xxi. Towards the end of May, Jessica presented at CGL. She stated that she was feeling suicidal and recognised that she had two options, *'either call a taxi and go to her dealer or get a taxi to CGL and ask for help'.* When asked how she was feeling now, she claimed that her mood had improved and when asked when she had last used substances, she said that it was a week since she had *'used'* but that she had smoked cannabis since. She refused to see her GP for injecting lumps on her arm, so was advised to go to the Emergency Department (ED) if signs of infection were noticed. She stated that she would like to go to a residential rehabilitation centre. She was advised that this was an option, but that CGL would need to liaise with her GP. Her recovery coordinator was informed, and it was agreed she would contact Jessica the following week and again encourage her to engage in treatment.

xxii. Attempts by CGL to reach Jessica by telephone over the next few days were unsuccessful and, although she sent a text message stating, *'I am still detoxing',* she did not answer the subsequent phone call. When, later that day, she did contact her recovery co-ordinator, she sounded tearful and said that she needed

to attend CGL every day to stop using but had no money or car. She asked if CGL could fund her bus fare but was advised that this was not something routinely offered. She did, however, subsequently have her bus fares refunded.

xxiii. During the call Jessica reported having used heroin once in the last week and was congratulated on this reduction. She also stated that she believed she was bipolar although this had not been formally diagnosed, and that she only weighed 6 stone but ate very little due to a lack of appetite and money. She declined the offer of a food bank voucher stating she would not be able get there. It was noted that she was less tearful by the end of the call.

xxiv. When CGL telephoned Jessica three days later, however, she was again tearful saying that she had *'failed'* and used that morning. Her son had given her money for a bus ticket, and she wanted to attend that day but requested daily one-to-one appointments. It was reiterated that CGL could not facilitate this but that she could attend groupwork daily alongside regular appointments with her recovery co-ordinator. She was advised of the Addiction Support group and the opiate drop-in group the following day and encouraged to attend these as well as weekly acupuncture to help with mood and relaxation. Jessica asked if she could have a refund on her bus ticket today as she could then use the money to buy a ticket the following day. This was agreed and she was advised to attend the service to collect this.

xxv. Jessica then stated that she wished she had enough money to *'kill herself with'*. She was advised of the mental health First Response Service but stated she would not ring them if she needed help because at that point she would not want to be stopped. When probed further she stated that the moment had now passed. The benefits to her mood of ceasing illicit use and commencing OST were again highlighted but Jessica stated that the nearest pharmacy was a 4 mile walk and that she would not be able to do the walk on the initial low dose as she would be too unwell. She said her preferred method of treatment would be a reducing dihydrocodeine script. She was informed that CGL were not able prescribe dihydrocodeine due to it being a pain management medication that was not used for addiction management. Jessica was again advised of groups that were available for her to attend over the coming days.

xxvi. Two days later in early June, East Ambulance took a call relating to Jessica who was in a suicidal state. The call handler tried to speak to her, recording that she shouted that she didn't need an ambulance and to '*stop calling'*.

xxvii. Between early June 2022 and January 2024 there were nine ambulance calls for Krzysztof. These were variously for suicidal feelings, overdose and assaults against him by strangers. At the first call he was slumped in his car seemingly overdosed and living in the car. Following this he went into homeless accommodation and then semi-permanent housing until Jessica's death.

xxviii. A few days after Jessica's call to the ambulance service, her CGL recovery co-ordinator made a check-in call. Jessica stated that things *'weren't great'.* A male voice could be heard talking over Jessica, so her recovery co-ordinator asked if this was a good time to talk. Jessica confirmed that it wasn't, and a follow-up call was arranged. She did not answer that call, or any of calls made by CGL over the next couple of weeks. A letter was sent at the end of June asking Jessica if she still required support from CGL as she had not attended groups or engaged with support offered and not been contactable. It was requested she contact CGL within 2 weeks if she wished to remain in treatment; she was also advised that she could self-refer to CGL at any time should she wish to access support.

xxix. In the interim, towards the end of June a concern for safety was reported to the police by ambulance control in Norwich relating to a female lacking in mental capacity who had taken Diazepam and was refusing to go to hospital. She had identified herself as Jessica and was alleging sexual assault but continually walking away from the paramedics. She was reported to be endangering herself and the public by walking in the road and so police officers attended and searched but found no trace of her.

xxx. At the end of June, the police were called to an incident at Jessica's former home where her ex-husband and children lived. Jessica had become distressed, spat at her ex-husband and caused damage to his car. He advised police that this was because her youngest child had not wished to see her. She had left the scene, and her ex-husband was not willing to pursue a complaint against her. He was offered safeguarding advice, and a Domestic Violence Protection Notice (DVPN)[19] was considered but deemed unnecessary.

xxxi. In mid-July, having not been able to contact Jessica via calls or letter, CGL discharged her from the service.

[19] DVPN - A DVPN is an emergency non-molestation and eviction notice which can be issued to a perpetrator by the police, when attending to a domestic abuse incident.

xxxii. In mid-August, police were called by staff at a fast-food restaurant as a woman, identified as Jessica, had left her dog outside and was injecting drugs in the bathroom. She refused ambulance treatment and went to her former home. She was subsequently detained under Section 136 (S136)[20] of the Mental Health Act and escorted by police officers to a local hospital. Mental Health and MASH referrals were made. On admission Jessica refused to see the Hospital Liaison Psychiatry Service. There was no further documentation regarding the outcome of the S136.

xxxiii. Five days later Jessica contacted the police stating that, *'travellers[21] were out to get [her]'* and the Joint Response Vehicle (JRV) attended.[22] She was not deemed to present an immediate mental health concern, and a conversation ensued about her use of heroin and crack cocaine. Jessica stated that she did not wish to use Methadone and would detox herself on Codeine. She was encouraged to work with CGL. The following day she went to her former family home stating she had been kidnapped by *'travellers'*. She was escorted home by JRV responders. She made three further reports through September of this issue and the IMR author notes *'No offences were revealed, with no trace of any additional referrals.'*

xxxiv. At the start of September, Jessica contacted CGL requesting to see a prescriber that day. She was advised that she would need an appointment for a comprehensive assessment prior to a clinical appointment being offered, and that an appointment was required for this as there was limited capacity for *'walk-in'* appointments and she ended the telephone call. Jessica's friend, referred to as *'she'* in the records, called to express concerns about the walk-in advice and was given the same information.

xxxv. During September Jessica had contact with the police on six occasions either due to calls regarding her behaviour, behaviour towards her or through calling them herself to report concerns about being stalked by the *'travellers'*. On one occasion, despite Jessica refusing referrals, the attending officer was concerned about her mental health and the unsanitary conditions in her home and made a

[20] Section 136 of the Mental Health Act 1983 allows police officers to remove someone from a public place to a place of safety if they appear to be suffering from a mental disorder and are in need of immediate care or control. This power is used when a person's behaviour is a cause for concern, and they need to be assessed by mental health professionals.

[21] This is Jessica's word as captured in agency records. She appears to be speaking about local drug dealers; the use of her own word is not intended to imply a conflation of criminal behaviour with travelling communities by the review panel.

[22] JRV is a joint response by police and mental health practitioners, an innovative initiative recognised by a nomination for an NHS Parliamentary Award in 2023.

MASH referral. They shared the information with the mental health front door service for CPFT – ARC and LADS (Liaison and Diversionary Service). ARC responded, *'the person related to this 102 is not open to any of our CPFT teams. Due to a policy change, we are unable to process the alert in this instance and any future alerts where the person related is not open to any of our teams.'* Safeguarding referrals were made throughout this period.

xxxvi. In mid-October Jessica telephoned the police stating that she was being chased and was hiding in a public toilet. When the officers arrived, her presentation was believed to primarily be due to substance misuse. Jessica was angry that professionals did not believe she was at risk of harm from others and that they believed her experiences were due to her mental ill health and substance misuse, and therefore she declined to engage with the mental health practitioner further and said she was going home. The situation was discussed with the out of hours Emergency Duty Team (EDT), and the use of police powers under S136 of the Mental Health Act was deemed to be an inappropriate response to the situation and therefore was not used on this occasion.

xxxvii. One-week later Jessica was seen in public with a bread knife and pruning shears which was reported to the police. She believed, *'persons were breaking into her house and threatening her… Police assessment of the allegations indicated there was no evidence to support any forced entry or damage and no witnesses to support these assertions. The review concluded this incident was isolated with mitigating factors related to [Jessica's] mental health.'* She was assessed by LADS, who completed a holistic vulnerability triage and a suicide risk assessment in line with policy. Jessica is noted as telling the LADS practitioner that her main concerns were homelessness and loneliness. She was asked about relationships and spoke about her family but was not asked about domestic abuse specifically.

xxxviii. Jessica was deemed fit to be interviewed. Because she had made a full admission, had not threatened to harm anyone, and witnesses were not distressed, police finalised this as no further action, requesting that Jessica engage with mental health services, and a MASH referral was made. Prior to leaving, Jessica agreed a release plan and accepted the offer of support from a LADS outreach worker to support her with practical tasks such as housing matters, accessing and attending substance misuse appointments with CGL, and accessing and attending any GP appointments for investigation of physical health concerns.

xxxix. At the start of November, Jessica telephoned the police, again stating that she was being chased by *'travellers*.' It is noted that she was *'reassured'* and declined to speak to a mental health practitioner, becoming frustrated that this meant she was not believed.

xl. At this time, Jessica's dog bit a member of the public and was subsequently seized following further attacks.

xli. Throughout December, the police service had contact with Jessica on nine occasions. These were related to her reports that she had been subject to theft, had had verbal arguments/ threatening behaviour with family, neighbours and the public, an incident with her dog, a neighbour reporting that she was distressed and *'smashing things up'* in her home, a fire at her home and an incident at a hotel where she was expressing the idea that the phones were bugged (she had been housed there following the house fire). For these incidents the police made onward referrals to MASH and other appropriate services, such as CGL.

xlii. Between December and mid-January, Jessica was accommodated in three temporary settings, all of which were ended by the respective housing providers for issues related to her drug use. She was accommodated in longer-term housing after this time.

xliii. Whilst under arrest for arson related to the fire at her home, Jessica alleged that she had been assaulted a few weeks earlier by travellers in a local park and had had her handbag stolen (containing her passport, medication and mobile phone). She refused to provide any further details because she did not trust the police. The report was finalised Type 14 (evidential difficulties).

xliv. At the end of the year Jessica was taken to hospital by police as they were concerned for her welfare; she was stating that she had been sexually abused but would not give details. She would not agree to have any medical interventions in the hospital but was asking to stay there. In the ED she was seen by two members of the Liaison Psychiatry Service (who completed an assessment of her mental health needs). The case was also discussed with the on-call Consultant Psychiatrist. They were unable to gain information from family members because Jessica could not provide telephone numbers that worked. Additionally, as it was the eve of a bank holiday, the Liaison Psychiatry Service was also unable to liaise with CGL for information as per normal procedure.

xlv. Jessica admitted to having used crack cocaine the previous day and was stating that she was unsafe. Liaison Psychiatry Service recognised a pattern of increasing contact with emergency services and noted, *'growing concerns over her expressing paranoid ideas, however the assessors were unclear if her presentation was a drug induced acute psychosis which might have resolved once the substances wore off, or an underlying psychiatric condition that would benefit from treatment.'* Options for admission were explored, but there were no hospital psychiatric beds available; it was agreed Jessica could stay in the ED overnight. Liaison Psychiatry Service considered community support options but documented that this was likely to be problematic as Jessica had a history of *'poor engagement'* and was adamant she did not want to return to her temporary accommodation.

xlvi. The following day Jessica's mental state was seen to have improved, and she said she wanted to return home rather than accept an admission to hospital. A suicide risk screen was completed as part of discharge planning and, with Jessica's consent, a referral was made to the hospital's Crisis Resolution Home Treatment Team for further assessment to establish if there was any underlying psychotic illness. She was discharged from the ED and went back to her accommodation on the last day of the year. A referral was also made for a Mental Health Act (1983) assessment.

xlvii. Later that day the police took Jessica to hospital again as she was distressed in a shop, stating that she was in danger *'of being hurt, killed and raped'* by persons unknown and needed a place of safety. She did not trust the police or ambulance staff but was taken to hospital believed to be suffering from a drug-induced psychosis. Officers made onward referrals.

2023

i) In the first few days of January, the Crisis Resolution Home Treatment Team recorded that, *'many attempts were made to try to contact Jessica over the next four days with no response and, she was no longer at the stated accommodation, so the referral was closed.'* The IMR author noted, *'Their efforts to contact Jessica exceeded the referral guidance and evidenced good practice.'*

ii) Within this period, Jessica was found in the hospital with multiple self-inflicted wounds. It was noted by the Liaison Psychiatry Service that she was *'initially uncooperative with staff, expressing paranoid ideas about their intentions and harvesting organs… talked continuously about being gaslit by a man who said if she left the [temporary accommodation] she would be killed.'* They also noted

that a male friend was with her and had told staff that Jessica had become upset when asked to leave her temporary accommodation, had self-harmed at the train station and then walked to the hospital. Jessica stated that she had self-harmed in the hospital, and the assessing practitioner was unable to determine intention for this self-harm (whether this was with suicidal intent or in response to paranoid ideation).

iii) It was noted that Jessica had drug paraphernalia and admitted to using drugs. The male friend attempted to claim that pills found in her bed were his and it was also noted that he appeared to attempt to sell drugs in the hospital staff restaurant, so he was asked to leave the hospital. Jessica asked for Morphine which was refused. There was a *'high priority reminder'* on Jessica's electronic health record system, made by her GP, in which it stated strict weekly prescriptions of Codeine, Pregabalin and Diazepam only and not to issue additional treatment of controlled drugs. This alert was visible to the Liaison Psychiatry Service and other hospital staff to minimise the opportunity for overdose.

iv) Once she was medically fit for discharge, Jessica was provided with a taxi to take her to the housing department and was signposted to CGL and the mental health First Response Service. She was later arrested for attempting to steal a yoghurt in a shop, describing to the Joint Response Vehicle responders that she was trying to get arrested for her safety. Safeguarding referrals were made for MASH and to CGL, and she was released without charge.

v) Two days later Jessica was drowsy, vomiting and weak in the hospital; she had been found there and appeared to be withdrawing from heroin having stated that she hadn't used in two days. She said that she had been given temporary accommodation 50 miles away and was unable to get there, so had come to the hospital. She asked for help with her mental health and a safe place to stay. ED healthcare staff attempted to call the housing department for her but were advised to make a referral by email. The early intervention team did speak to housing after sending the requested email who confirmed she had been offered temporary accommodation. She was diagnosed with opioid-induced mental disorder not deemed as an acute issue warranting admission. She was later discharged with crisis support numbers, a taxi to take her to her accommodation and a supply of food.

vi) Two days after that, Jessica's GP referred her for psychological services for low mood, and she was offered a talking therapies service appointment for the end

of March. She phoned CGL three days later, in mid-January, requesting treatment and was advised that she would need to be called back with an appointment. She stated that she had no phone due to her house fire and agreed that she would call back the following day. She was discussed in the team meeting with an agreement that she should attend as a *'walk-in'* and undergo a comprehensive assessment. It was also noted later that the MASH team had previously updated CGL that Jessica had disclosed to police that she was not comfortable attending CGL sites in her former area as she would be tempted to use drugs. Consequently, it was agreed that she could walk-in at another site. CGL recorded several updates at this time from adult safeguarding relating to Jessica's police interactions at the end of December.

vii) Jessica emailed the service requesting treatment three days after her last contact. A response was sent regarding her being able to attend an alternative site and, with no response, CGL made attempts to contact her via her old phone number and the temporary accommodation (an automated message advised that the service was unavailable). They also sought alternative points of contact from police colleagues. They did secure contact and offered an assessment; she was given an appointment which she did not attend but she did attend the next appointment in the first week of February.

viii) On assessment with CGL, Jessica disclosed wishing to have support with her mental health and addiction recovery. She described bereavement as being a trigger for her poor mental health and stated that she had suffered with chronic back pain for which she had been prescribed opioids that had led her into a journey of addiction. She was offered a comprehensive community treatment plan and CGL liaised with her GP. She attended her medical assessment for OST. During contacts with CGL her suicidal ideation and suicide risks were explored. Jessica continued to engage with CGL through February proactively seeking her BBV test[23] results and liaising regarding her prescription collections.

ix) In February Krzysztof was released from a short period of detention and was overseen by a probation officer. He continued to have police interactions (public indecency for public urination being one of them). He was street homeless on his release.

[23] A Blood Borne Virus (BBV) test is a medical procedure used to detect the presence of certain viruses that can be transmitted through blood or bodily fluids. These viruses include HIV, Hepatitis B, and Hepatitis C. BBV testing is crucial for early detection, enabling timely intervention and treatment, which can improve health outcomes and reduce the risk of transmission.

x) In March Jessica was evicted by her former housing provider (CHS) due to rent arrears. She was then housed in another location by an alternative provider (P3).

xi) At the start of March Jessica continued to work proactively with CGL. She was managing her prescription needs and began attending a Cognitive Behavioural Therapy (CBT) group. In mid-March she attended the ED with visual disturbance wishing to have her vision checked. She noted that this was something that happened when she was using drugs or tired. She was encouraged to see the LPS, but self-discharged stating she would visit the optician. She later returned, with the record noting, *'unable to explain what she wants from being there.'* She admitted using cocaine and self-discharged again.

xii) A CGL meeting record for mid-March stated, *'spoke with her recovery coordinator… struggling with her mental health, had been pretending to take her methadone [at times] … OCD tendencies and trauma induced mental health issues which she felt she had not dealt with (the death of her son). She was advised that she should take her OST as directed to prevent withdrawal symptoms… recovery coordinator also stated she would speak with the CGL co-occurring conditions lead in order to ascertain how best to support her with her mental health.'*

xiii) Having had ongoing issues with the police in March and having had a licence compliance letter issued, Krzysztof was compelled to book for an assessment with CGL and was seen in mid-March. On assessment he described alcohol and poly-drug misuse, needing support with mental ill health and having been suicidal following the breakdown of his marriage one year earlier. He also described an incident of domestic abuse, *'where he assaulted his ex-girlfriend but stated that this was in self-defence as they had been fighting, and he described the relationship as toxic. He also identified alcohol as a trigger for his aggressive behaviour.'* He worked with CGL over the coming weeks, attending groups and other appointments.

xiv) At the end of March, talking therapies contacted Jessica for her appointment and she requested that it was rearranged as she was moving home. She also saw her GP and described taking additional pain medications; they liaised with her coordinator at CGL.

xv) Throughout April Krzysztof attended CGL services, joining groups and undertaking assessments. He was noted to be working towards abstinence and on one occasion stated that he was struggling with alcohol consumption as he was accommodated in shared housing where others drank. However, after

stating this, he did move and was reported to have an improvement in his wellbeing. He continued to engage with CGL.

xvi) In April, Jessica attended the Citizens Advice Bureau (CAB) to discuss grants, utilities access and budgeting advice, but did not collect her OST early in the month. She attended CGL for a restart of this in mid-April. She tested positive for poly-drug use and was advised about possible overdose risks. The consultant psychiatrist noted, *'low mood, speech was monotonous and impoverished, and she had psychomotor retardation.'* She continued to work with CGL in April, keeping them informed of her change of phone number and advising them that her probation officer would liaise with them, *'regarding her getting her dog back.'*

xvii) CPFT recorded, later in April, an assessment appointment in which, *'she felt her brain was in a 'pickle' but thought her recent move to Cambridge was a positive new start for her. She described her mood as very changeable and that she had lots of social anxiety and was 'rubbish' at relationships and didn't like herself as a person.'* She was questioned regarding suicide risks but denied any current feelings; she said that friends were a protective factor in this regard and was referred for a *'Is this for me'* support group. She did not respond to emails inviting and reminding her about the group and was subsequently closed to the service.

xviii) Throughout May Krzysztof continued to engage with the *'Foundations of Rehab'* group work at CGL.

xix) In May, Jessica was subject to a Drug Rehabilitation Requirement (DRR) by the Magistrates' Court after being found to have a dog dangerously out of control. She expressed at a CGL appointment a desire to reduce her OST as she had missed some and *'was not experiencing withdrawals'* – her treatment was being transferred to the CGL criminal justice team because of the DRR, and late in the month, she saw the consultant psychiatrist with a view to restarting her OST and disclosed continuing to have poly-drug use. She did not attend her first mandatory appointment at the end of May.

xx) In June, Krzysztof disclosed binge drinking to celebrate completing a course, and staff at his supported accommodation reported aggression to another resident. He continued to drink and his attendance at CGL reduced. Later in the month he attended group, stating that he had PTSD from his life experiences and shame and guilt for the things he had done to others. At the end of June, he was subject to an Alcohol Treatment Requirement (ATR) by the Magistrates' Court for *'intentional harassment.'* This was a matter unrelated to Jessica.

xxi) At her mandated appointments in early June, Jessica disclosed experiencing trauma in her marriage (*'mental abuse'*) and feeling hurt at limited contact with her children.

xxii) Jessica was admitted to hospital in mid-June with *'facial droop and choking on food'*. She was thought to have an infection but wished to go home to care for her dog. She advised that she was not injecting but had, *'recently split from partner'* – her ex-husband was visiting her, but she did not want information shared with her family. The hospital noted ongoing issues with her ex-husband, *'possibly troubled and abusive relationship between them.'* During the stay she was seen by a psychiatrist and stated that she still believed the police were monitoring her and had *'placed a tracking device in her.'* Her delusions were noted to have reduced, and CGL were given prescription advice to reduce overdose risks. She self-discharged after 4 days against medical advice.

xxiii) Towards the end of June Jessica attended the CGL Women's Group. She discussed grief and trauma and her journey into addiction. She was unable to provide a urine sample. On the same day, she presented at hospital (but did not stay for treatment) and admitted that she had been *'bingeing on drugs.'* It had been her son's birthday. CGL spoke with her probation officer and arranged a joint visit due to concerns about ongoing drug use and possible overdose risks.

xxiv) In July, Krzysztof started working and CGL endeavoured to accommodate his hours. He was not seen again until the start of August for his mandated ATR and described drinking less due to daytime working hours.

xxv) Throughout July, Jessica attended the CGL women's group and said that it had been the anniversary of her son's death. She continued to disclose and test positively for poly-drug use. In mid-July she saw the consultant psychiatrist and requested opioid blocker treatment. Her mental health was explored, and her harm reduction plan was updated. She was changed to Espranor[24] as part of a detox plan. She was urged to continue with psycho-social interventions through CGL support. She attempted a self-detox at the end of July which was unsuccessful. At her prescribing appointment she stated that she *'did not feel capable of addressing some of the underlying reasons for her substance misuse and she was reassured that stability on OST would provide her with the capacity to do so at a later date.'*

[24] Espranor tends to be easier to detox from than methadone. Some people take methadone long- term to maintain abstinence from heroin use but switch to Espranor if they decide to detox. Espranor is often safer if taken in overdose than methadone.

xxvi) In early August Jessica disclosed to her substance workers that she had '*used'* with some people she had met at the *'Foundations for Rehab'* group. She requested online groups as face to face was a trigger for her to use but was advised that this may not be possible given her court order. She continued to express a desire to be abstinent. It was later agreed that she could attend online groups from September.

xxvii) Later that month, Jessica informed CGL that she had had further lapses due to meeting, *'a friend whilst attending DRR and they had gone back to her property and used drugs.'* On the same day she called the police, reporting a burglary in progress and stating that a male [name given resembles that of Krzysztof] '*was in the property armed with a knife [and] wanted his heroin.'* No-one was present when police attended; they referred to MASH and a decision was later made by that team not to share information with partner agencies.

xxviii) At the end of August CPFT received a referral for Jessica to receive treatment for bipolar disorder and PTSD (Post-Traumatic Stress Disorder). They wrote back to the GP, *'stating there was no diagnosis of bipolar disorder and therefore treatment could not be given for this diagnosis, but that if Jessica was ready to engage in primary care talking therapies for PTSD symptoms, then she could be placed on the waiting list along with a referral to REDS[25] "Is this for me" group.'* Attempts to contact her in early September were unsuccessful.

xxix) In September Jessica commenced the online CGL groups, attending throughout the month. Her relationship with CGL and Probation was noted by CGL to be changing; she had been erratic in prescription collection and was insistent on a reduced collection regime which was not allowed under the terms of her court order. At her mid-September joint meeting with CGL and Probation, she was *'agitated',* unhappy about attending and was calling agencies *'liars'* – she stated she would *'put up with withdrawal rather than attend pharmacy every day'* stating that she was not a heroin user and *'not like them'*; she did describe overusing other medications and using cannabis and crack cocaine.

xxx) In mid-September Krzysztof was sentenced to a 12-month community order for assaulting an emergency worker. Later that month he attended CGL group stating a reduction in drinking as his goal.

[25] Relational Emotional Difficulties Service

xxxi) In early October Jessica reported having been free from opiates for 20 days and tested positive only for benzodiazepines.[26] CPFT processed a referral for talking therapies, refusing this due to Jessica's *'high needs'* and advising the GP that they should refer to the REDS programme.

xxxii) In mid-October at her women's group, Jessica discussed her roles as wife and mother and her need to seek identity and purpose and reduce substance misuse. Krzysztof described feeling positive at his group. Having *'come a long way'* since prison the year before and having contact with his daughter, he acknowledged that some substances brought out the *'damaging aspects of his personality'*. CGL had previously made a Children's Social Care referral relating to Krzysztof's daughter and now received feedback that there were no concerns as he was addressing his behaviour and having contact in public places.

xxxiii) Jessica's contact with CGL reduced in October; she had enquired about the end point of her court order and had been advised that it was due to expire in early November. During November, Jessica stopped attending and Krzysztof is noted to have increased his alcohol use. Jessica had limited contact with agencies other than her GP.

xxxiv) In mid-December she contacted the police who responded with the JRV. She reported a burglary, saying that '*someone had been tampering with her gas and that the neighbour had threatened to kill her dog'*. Jessica ended the call and when the police control called her back, she could not remember making the call but stated that someone had replaced her back door. On police arrival, Jessica was not at home so could not be triaged by the mental health practitioner. The police decided they would follow up the following day.

xxxv) Jessica was later brought to hospital by ambulance on a Section 136, having been found trying to walk into traffic on the motorway. The Ambulance Service recorded, *'AMHP [Approved Mental Health Practitioner] office contacted for assessment. Jessica accused hospital staff of lying to her and trying to poison her. Reports having been clean from drugs for 2 months but admitted to drug use that day including an overdose. Not believed to have capacity and possible drug induced psychosis. Whilst awaiting assessment became aggressive and spat at police so was arrested and spit hood placed on her.'* The hospital deemed that due to her substance misuse it was not appropriate for her to be placed in the mental health suite and that she should be assessed in the ED. The following day

[26] Benzodiazepines are depressants that produce sedation and hypnosis, relieve anxiety and muscle spasms, and reduce seizures, for example, Diazepam.

she presented as *'okay'* and was *'dismissive of the prior day's concerns and that she might want to hurt herself.'* Her lack of psychotic thoughts or current suicidal ideation led the medical staff to determine that she did not meet the threshold for detention under the Mental Health Act. She was discharged with encouragement to pursue a REDS referral with her GP, work with CGL, use emergency services and contact CRUSE for bereavement support. Relationships were explored but she was not directly asked about domestic abuse.

xxxvi) On the same day, Krzysztof was taken to hospital heavily intoxicated, stating that he had taken heroin that day. Three days later he was asked by CGL what support he would like when his ATR ended and they recorded, *'due to his alcohol use having reduced he would not require support from CGL after he had completed his ATR. He reported no issues with his health and stated he still needed to see his GP regarding his depression and anxiety and was encouraged to do so. He reported ongoing contact with his daughter and when asked about his relationship status he reported that he remained single. No further risks were identified.'*

xxxvii) Jessica attended her GP just before Christmas requesting that they check her lips as she believed she was being poisoned by sodium chloride. Her GP recorded, *'I suspected she was under the influence of drugs again.'*

xxxviii) CPFT received a referral and scheduled a triage assessment call for Jessica relating to her need to access the REDS group for early January.

2024

i) During the assessment call for REDS, Jessica is noted to have *'engaged well with the phone triage and was recorded as pleasant and polite.'* The notes went on to say that she wanted to explore the use of talking therapy to manage PTSD symptoms and PMS (premenstrual syndrome). The recommendation was for REDS first, due to her mood dysregulation and distress tolerance, before therapy for PTSD. She was offered a referral back to REDS and it is recorded that '*she was grateful for this and reported that she had experienced some challenges… and was willing to engage in the program. She was asked about risk but reported none. As Jessica was already referred to REDS, they sent Jessica an email inviting her to attend their workshop 'Is This for Me?'* Jessica called REDS at the end of January to opt into the program and was added to the waiting list.

ii) The day after this call Jessica requested emergency contraception from her GP following *'consensual unprotected intercourse'*. Sexual health advice was given with *'no concerns about her mental state'* noted.

iii) At the end of January, CGL wrote to Jessica outlining her treatment options. She had missed a neurology appointment, which the IMR author noted may have been due to discrepancies on the appointment letter. She saw her GP, describing regular but erratic drug use and needing *'something'* for her mental health. The GP suggested multiple options with Jessica *'in two minds'* about the various ideas. They settled on Promethazine[27] on a low dose, and a continued slow reduction of Pregabalin[28] and continued Diazepam. At around the same time, Krzysztof was sent a closing letter with advice for self-referral for CGL following a period of non-engagement.

iv) Jessica disclosed to her probation practitioner that her bank card had been blocked, that she believed her calls were being monitored and that she was in a relationship (but did not say who with). She also disclosed her back door being broken and not feeling safe.

v) The day after seeing her GP, Jessica called and requested to start using Quetiapine[29] as this had been an option previously discussed; a prescription was given.

vi) At the end of January Krzysztof disclosed to his probation practitioner that he was in a relationship with Jessica. They record, *'[A former boyfriend] is jealous of his relationship… [and that] he is working on a fruit and veg stall which was the [former boyfriend's] old job.'*

vii) At the end of January Jessica was taken to hospital by police. She was *'muddled in her speech'* and was assessed for mental capacity; she was deemed not to have mental capacity and was taken to a ward having taken an overdose of Diazepam in the ED. She reported having met a male two weeks previously, *'Reports heavy cannabis use since then and Jessica reports feeling like the male has been lacing her cannabis with other substances. Jessica states that male and others have been implanting drugs under her skin and poisoning her with mercury.'* She was heard talking on an off to her partner on the phone, *'Jessica reported they were repeatedly calling each other arguing and then hanging up.'*

[27] An antihistamine with a drowsy effect
[28] Anti-anxiety medication
[29] An atypical antipsychotic medication used in the treatment of schizophrenia, bipolar disorder, bipolar depression and major depressive disorder.

viii) It was noted by the Cambridge University Hospital Trust (CUHT) IMR author that Krzysztof was well known to them for drug use and domestic abuse as well as for a general tendency to violence and aggression which increased when his substance use escalated.

ix) Jessica was seen by a registrar and advised them that she was worried about her dog and did not trust her boyfriend to take care of it as he, *'has a drinking habit and acts inappropriately when intoxicated'*. She disclosed concerns about her sexual health. The following day she expressed ongoing *'paranoid'* thoughts, and that she suspected that her boyfriend had given her a drug which he stated was amphetamine, but which wasn't. She also stated that she later woke up with her trousers on back to front, with *'sperm on them'*. She was advised of rape crisis support but stated that she did not want to progress the matter. The psychiatrist, *'despite Jessica's other delusional statements'* found these claims plausible, considering her to be vulnerable. The psychiatric team felt that her presentation was related to drug use and would wear off. However, the psychiatrist did feel that there was evidence to suggest a chronic psychotic illness during the previous 12-15 months but did not feel that detainment under the Mental Health Act was necessary. A social care referral was made along with a referral to the Crisis Response Home Treatment Team (CRHTT), and CAMEO - a specialist psychosis service - and she was discharged.

x) CRHTT called Jessica the following day and she agreed to start an extended assessment. She requested that her boyfriend be present as he would stay with her overnight as she felt unsafe at home. When the team arrived for the assessment, she requested a reschedule, stating that her Quetiapine [which had been increased in hospital] had made her too tired. A call was arranged for later that day. During the call she was offered a visit but declined and they recorded, *'Jessica said she experiences paranoia and becomes hypervigilant. She was asked about home safety and possible wires sticking out of the wall. She confirmed this, there were things that she 'had done, but they were now 'undone'. She said she had also seen wires coming out of the police station when she went there a few days ago. Jessica said the times she ends up going to hospital 'in a state' had been when she had taken drugs and people around her know the state she is in, so they take her to hospital, but she believes she also gets in that 'state' when she hasn't taken drugs, she just feels people around her don't notice and therefore she does not go to hospital. She believed that if she had a mental health number to call, she would not require attendance at hospital. Jessica was given crisis numbers.'*

xi) The following day, at the end of January, the CAMEO service called Jessica and noted *'pressured speech',* that she described various agencies as *'terrorists'* who *'plant people in the street to bump into her'* and that she had *'blue flashing lights following her at home'*. When asked what could have triggered this crisis, she identified *'poor sleep and having sex for the first time in years.'* She described induced vomiting and hot baths as a self-harming technique but no cutting. She was offered and accepted an assessment.

xii) The CRHTT stayed in touch with Jessica, phoning her the day after she had spoken to CAMEO and noting, *'Jessica recognised her mental state had improved since attending the ED but felt she had struggled with her mental health for several years. The practitioner asked her about some of the statements she had made in the ED to establish if some of her delusional beliefs remained. She continued to be suspicious of CGL and believed they were working with the government in conducting experiments... recorded pressured speech and tangential talking almost continuous for 30 minutes and difficult to interrupt her. Jessica admitted to taking cocaine the previous night and smoking cannabis that morning... She stated she had not taken her prescribed medication Quetiapine 100mg because she believed that taking her prescribed medication would result in heavy menstrual bleeding... they were not able to assess her mental state accurately free from substances.'* During this assessment she described her boyfriend as *'supportive'* and *'comforting'*. Her next CAMEO appointment was scheduled for the following week, which Jessica cancelled.

xiii) The CRHTT assessor was aware Jessica had been referred to CAMEO for diagnostic clarity, psychoeducation, and optimization of antipsychotics. Notes record that Jessica, *'wanted to engage with Cameo as she wondered whether she had obsessive compulsive disorder or bipolar disorder and would like support with past trauma experiences.'* The following day her GP received notice that she had been discharged from CRHTT as, *'acute persecutory psychosis, likely related to drug use, has substantially improved since discharge.'*

xiv) The day after that, Jessica reported to police that a male was refusing to leave her property and had threatened to assault her. The police identified this as Krzysztof. She disclosed that the stress of the incident had caused her to self-harm and police records state that she had *'small cuts to her left wrist and left leg.'* He was removed from the property and charged with common assault. Jessica did not wish to participate in a risk assessment, give a statement or support a prosecution, stating that she feared reprisals from his gang-related

criminality. A DASH risk assessment, based on professional judgement, identified Jessica as at medium risk of harm. An Adult Protection referral was completed. A MASH entry refers to the couple, *'being well known to police and their relationship being chaotic, giving cause for concern and potential for escalation of vulnerability and risks should it continue. Information from the referrals was not shared with partner agencies based on 'no consent'.*

xv) Two days later Jessica spoke to her GP about a prescription and requested contraception, stating that her relationship was over but that she would like protection going forward. Two days after this, Krzysztof phoned the police and reported Jessica assaulting him at her home address. The police noted, *'both parties sustaining injuries consistent with the offence of ABH. Neither Jessica nor Krzysztof wished to pursue any complaints or support an investigation, and both refused to complete DASH RA and statements. Krzysztof was removed from Jessica's home to his own address. Given that both were making counter allegations… each were recorded as victim and perpetrator. No other persons were present at the time of the altercation. In the absence of any other supporting evidence, the reports were finalised NFA.'*

xvi) CGL contacted Jessica the day after this incident. She said she would like ongoing treatment, and Krzysztof attended his group on the same day. He was turned away as he was intoxicated and had been drinking in the foyer, after a member of staff had cleaned his hand which was grazed. Krzysztof was subject to a RAR (Rehabilitation Activity Requirement) at this time. He was reminded of this due to erratic engagement. In the latter part of February, he did not attend the groups. CGL raised a concern with his probation practitioner in early February regarding his and the public's welfare.

xvii) Towards the middle of February, Jessica presented at a police station. She *'suspected she was being cuckooed by three or four males involved in county lines criminality… unable to provide any physical descriptions/ names… nor could she offer any further details about her suspicions.'* She described thinking that they had tampered with her electricity and water, so officers offered to take her home and offered to do a sweep of her house. She accepted this offer and, once officers had completed a search of the property, they confirmed there was no indication of tampering or sabotage which was noted to reassure her. An Adult Protection referral was assessed as medium risk and submitted to MASH. MASH reviewed the referral and shared the information with CPFT and CGL. CGL record receiving this a week after and noting it on the system.

xviii) Two days later, Jessica requested antibiotics from her GP for a human bite. CAMEO continued to liaise with Jessica's GP and offer her assessment appointments, which were all cancelled at short notice. On one call she told the nurse, *'I don't even want to talk about the delusional stuff because it is embarrassing.'* She also stated that she had experienced lots of traumas and missed having someone to go to, giving the example of a mum or dad. She spoke positively about CGL stating she would work with them, and she declined a CAMEO assessment eventually. They were satisfied that her mental state had improved and planned to organise a follow up by REDS and CGL.

xix) Towards the end of February, Jessica was seen by her GP who noted that she was brighter and reported not using crack cocaine. She said that she was finding the Quetiapine helpful. Her probation practitioner was changed at this time due to the recognition that they were managing both Krzysztof and Jessica.

xx) After receiving a safeguarding referral from the police, CGL made contact with Jessica who restated her concerns about the organisation as, *'terrorists… providing her with fake medication and conducting experiments on her body.'* She also stated that she believed CGL were colluding with her husband to kill her. Following a clinical consultation, CGL referred her to the mental health FRS who advised she was under CAMEO and that if CGL felt she was a danger to herself or others they should contact emergency services. The CGL practitioner consulted with their internal co-occurring conditions lead, who determined that there was no further action they could take. They left a message for a call with Jessica's probation practitioner as she was still subject to a court treatment order, later discussing her unwillingness to work with CGL.

xxi) In the first week of March, Jessica was advised by email of the start of the REDS group sessions online. On the same day a neighbour contacted the police reporting concerns for her welfare. They had not seen Jessica since the last days of February and could hear her dog inside the house. Police spoke to Krzysztof who had alerted the neighbour. He said he had not seen her since the same date when, *'they had been taking drugs together.'* They had had a minor dispute, and his last contact was confirmed in a WhatsApp message. She was found deceased with a large laceration to her right forearm.

15. Analysis

The analysis has been organised under summary headings representative of the key lines of enquiry set out in the terms of reference, with key vulnerabilities prior to the scoping period being placed first to set the scene for Jessica's experiences.

Prior to the scoping period

i. Jessica was clearly a woman who loved her four children, as can be seen by her references to them when in contact with agencies, and in her family tribute. She expressed how difficult she found not having a lot of contact with them and/ or her relationship with them being affected by the path that her life took. For the purposes of the review, her children shared a photograph of a beautiful woman, smiling as she took a selfie, in a home that was attractively decorated, wearing a fashionable summer dress. The panel was conscious of the deterioration of Jessica's wellbeing in a relatively short space of time, showing the fragility of human existence in a modern, complex western society.

ii. One of Jessica's children had died at a young age following heart complications. She repeatedly told agencies that this was a traumatising experience, something from which she never recovered. At that time (20 years prior to her death) she was not offered and nor did she receive any therapeutic support with this loss, the most distressing a parent could ever face. Today it would be more likely that offers of support would be made by NHS staff to bereaved parents, which is represented in local policy and practice.

iii. The panel noted that Jessica consistently and persistently told agencies that she needed help with the post-traumatic stress that she had experienced. She also noted that she had been prescribed opioid painkiller medication for *'chronic back problems'* which had led her to become addicted to opioids, that she had resorted to buying OxyContin[30] from the dark web and that this had led to the use of heroin as a cheaper alternative.

[30] This drug is used to treat severe pain, for example after an operation or a serious injury, or pain from cancer. It is a controversial drug having been marketed by Purdue Pharma in such a way as to minimize the significant risks of addiction and overdose involved in its use (US Case Law: Harrington v. Purdue Pharma 2024).

iv. Jessica did seek help for her mental health from 2019 onwards but was not fully engaged by services, despite attempts by practitioners. In 2020 a second referral was made by her GP – citing chronic anxiety, depression and suspected PTSD. Covid interrupted the progress of this support as Jessica said that she would prefer face-to-face appointments and was appropriately signposted in the meantime. However, at this point practitioners were not aware that the ensuing lockdown periods would interrupt face-to-face work for most of that year and that hospital trusts would become overwhelmed with Covid-related demands. Jessica did eventually accept a virtual meeting in August but did not attend. However, she had completed a PTSD questionnaire in which she had identified several traumatic life experiences including house fires as a child. She was sent re-referral information. Unfortunately, Jessica's marriage broke down around this time, and she was not known to services again until ten months later.

v. The impact of Jessica's addiction to opioids was fully apparent in October 2021 when she was found in a car with injecting equipment and a large quantity of tablets. Police officers raised concerns with the MASH citing their concerns as, *'drug use, association with drug users, mental health, and lack of support.'*

vi. By Christmas 2021 she was showing signs of mental health deterioration, for example in three police interactions; in one of these, she would only speak to police through the letterbox and stated that she '*no longer felt safe to leave her home'* (2021: ii) and that she could hear her neighbours talking about her from within her home.

vii. The panel reflected, with the benefit of hindsight, on her journey into vulnerability and on the inevitable impact that it had on her and her family, wishing to acknowledge the importance of intervening early to prevent the resulting deterioration and distress. In the first instance, the panel wished the learning from this review to inform trauma-awareness across all agencies, so that agencies ask themselves, *'What is the context for how you find yourself here?',* seeking to address the root cause of issues.

viii. In Jessica's situation this learning would be around the recognition of the importance and value of offering individuals therapeutic support when something as significant as the death of a child occurs. It would also mean

recognising the potential for negative coping strategies, such as substance abuse, in the face of such overwhelming grief and pain.

Domestic Abuse

i. Domestic and sexual violence and abuse (DSVA) is an umbrella term that covers a range of differing interpersonal and family dynamics where abuse in different forms is acted out. Jessica believed that she had experienced *'mental abuse'* (2023: xxi) in her marriage, and agencies had some limited information regarding her experience of domestic abuse incidents with Krzysztof. Her children were clear that Jessica experienced violence and control from the outset in this relationship.

ii. As outlined in the Equality and Diversity section, DSVA places women at greater risk of experiencing the issue and at greater risk of serious harm. Women are far more likely to die at the hands of someone they know, and women are more likely to die by suicide than men in the context of domestic abuse. The panel observed that this data underpins the importance of our awareness of the significant psychological impact that DSVA has on women.

iii. In June 2023 Jessica disclosed prior domestic abuse in the form of psychological abuse (2023: xxi – 'mental abuse') in her marriage. From pre-scope records we know that police were called to physical and verbal disputes at the family home as far back as 2018. Risk was identified as 'Standard' meaning no onward referrals would have been made. The panel was unable to know the full extent of this; it could have been situational[31], especially as the couple had lost a child so tragically, and it is not within scope. Whatever happened though, her marriage ended. Her belief was that she had experienced abuse and contact with her children was affected. These were all significantly negative factors for her as a mother.

iv. Krzysztof was known to agencies as perpetrating domestic abuse towards his previous partner by assaulting her in May 2022. Risk was assessed as 'Medium' and the couple separated at this point. The risk assessment tool in use by the police in Cambridgeshire at that time was the DASH risk indicator checklist, an

[31] A Typology of Domestic Violence, Michael Johnson. 2008

incidentally used tool that uses an actuarial[32] and structured professional judgement approach.

v. We also know from the history that Krzysztof admitted to being [more] aggressive when under the influence of alcohol, stating to CGL practitioners that it brought out the *'damaging aspects of his personality.' (2023: xxxii)*

vi. The only overt knowledge that agencies had of domestic abuse between Krzysztof and Jessica related to her report of an assault in January 2024 when Krzysztof was removed from the property and charged with Common Assault. The police officers utilised good practice in undertaking a risk assessment based on professional judgement. They identified Jessica as being at medium risk of harm. The MASH entry following this incident stated that the couple were, *'well known to police and their relationship being chaotic, giving cause for concern and potential for escalation of vulnerability and risks should it continue*. *Information from the referrals was not shared with partner agencies based on 'no consent'*. (2024: xiv)

vii. The panel noted that Krzysztof was a known perpetrator of domestic abuse and that, according to recent research, he showed all of the other significant vulnerabilities that are known to be risk factors for interpersonal violence in adult safeguarding arenas – he was under 66 years old, had a criminal and violent history, was a drug and alcohol user, and had mental health problems and employment, housing and financial issues.[33] Jessica also disclosed self-harming because of this assault and was a high suicide risk given her circumstances and regular suicidal ideation. It was the view of the panel that Jessica could have been identified as at high risk of harm at this incident, which was a missed opportunity for a multiagency process.

viii. It was also the view of the panel that the MASH decision not to share information, along with the assessed medium risk level, was incongruent with the description of the relationship as having '*potential for escalation.'* Two days after this incident, Krzysztof reported an incident of assault from Jessica and the police noted, *'both parties sustaining injuries consistent with the offence of*

[32] Mathematical modelling of risk factors

[33] An analysis of domestic homicide review recommendations for adult safeguarding in England, Chantler et al. Journal of Adult Protection. 2024

ABH.' (2024: xv) The panel was of the view that in the context of the first incident and of Krzysztof's history, the police could reasonably have identified him as the primary aggressor with the likelihood that Jessica was using violent resistance.[34] This second incident, the panel believed, could definitely have led to a determination of Jessica being at high risk of harm on the basis of her risk of death by suicide – or DAIS[35] - due to the growing national recognition of the significant volume of deaths by suicide in the context of domestic abuse.

ix. This growing awareness is reflected by the police IMR author who noted that the College of Policing APP (Authorised Professional Practice) 2021 describes key considerations that should be made during the risk assessment process, which include understanding a person's vulnerability. The author recommends that there should be an increase to multi-agency suicide prevention training across the workforce.

x. The police IMR author also noted that there were issues regarding the *'credibility, reliability and veracity of the events [Jessica] alleged.'* This issue is complex given the multiple disadvantages that Jessica faced and is explored further below. The author further noted the issue of an incidental use of the DASH tool making it, *'dependent upon the score or number of ticks, to determine the grading. Consequently, incidents were dealt with in isolation, as opposed to adopting a person-centred approach, requiring officers/supervisors/managers to apply their professional judgement during the risk assessment process, thus seeing the 'bigger picture' which is imperative where there are co-existing vulnerabilities.'*

xi. Cambridgeshire have now introduced DARA[36] to replace the DASH risk assessment process. DARA is considered a broader assessment tool designed to encourage first responders to apply their professional judgement when attending or investigating domestic abuse related incidents. The DASH process has been retained until such time as training has been delivered across the entire workforce and currently only those officers/staff that have received the

[34] Michael Johnson, in his Typology of Domestic Violence (2008) identifies violent resistance as the act of resisting violence perpetrated against a victim, commonly used by women in the context of men's violence.
[35] DAIS – Domestic Abuse Induced Suicide
[36] Domestic Abuse Risk Assessment

DARA training are proactively utilising the procedure. It was the panel's recommendation that oversight is maintained by Cambridgeshire Police of the efficacy of this change of approach. They were also of the view that these examples presented missed opportunities for Jessica to be referred to a MARAC (Multi-Agency Risk Assessment Conference)[37] meeting and to an IDVA (Independent Domestic Violence Adviser).[38]

xii. In February Jessica presented at a police station stating that she '*suspected she was being cuckooed by three or four males involved in county lines criminality…'*. It was noted that she *was 'unable to provide any physical descriptions/ names… nor could she offer any further details about her suspicions.'* (2024: xvii) The officers did not dismiss her out of hand but took her home and checked her property over which was good practice. However, some curiosity and investigation of this in the context of the above incidents could have been warranted, especially in light of the possible exploitation discussed in the Multiple Disadvantages section below.

xiii. Further to this and to the previous incidents, the Police IMR author also noted that, irrespective of the risk level or whether Jessica felt able to engage, officers could still supply the details of domestic abuse services to make victims aware of their options for support.

xiv. The panel noted that there were other opportunities to recognise Jessica as a victim of domestic abuse. Tragically, they noted that she was never asked directly. There were multiple instances of the opportunity to ask the question or to notice the signs of risk in this area. Specifically, these arose in health settings and at the drug and alcohol service CGL.

xv. The panel noted that overall CGL were proactive and responsive in their practice, reaching out to Jessica through check-in calls and home visits which is good practice for those living with multiple disadvantages. They were also very responsive to Jessica's requests for clinical appointments at times when she contemplated change and undertook extensive multi-agency practice. There

[37] MARAC is a multi-agency meeting for those victims of domestic abuse deemed to be at high risk of harm.
[38] IDVAs are a specialist domestic abuse practitioner usually working for a local domestic abuse organisation.

were some gaps in contact noted by the IMR author - at the point of service transfer (between criminal justice and mainstream teams) or during/ after hospital admissions, and some gaps were noted in case recording. The organisation is undertaking actions to address these areas, and a period of understaffing that contributed to these was not an issue at the time that the report was written.

xvi. The panel further noted that there were missed opportunities to explore domestic abuse at CGL with both Jessica and Krzysztof. The IMR author identified that more opportunities to develop one-to-one conversations could have been created with Jessica which could have better enabled the exploration with her of her relationship, and the panel noted some key opportunities when red flags were raised and CGL staff might have had more professional curiosity.

xvii. In March 2022 Jessica described that she usually smoked heroin but, *'one of her friends will inject her this weekend.'* Professional curiosity as to the nature of this friend could have led to a conversation about Jessica's relationships. It is of note that the development of trusting relationships where these risk indicators can be shared would be good practice in the prevention of future harm as well as the understanding of current risks.

xviii. In June 2022 CGL called Jessica following an ambulance call out for suicidal feelings; this was good practice. The IMR author noted that, *'A male voice could be heard talking over Jessica, so her recovery co-ordinator asked if this was a good time to talk. Jessica confirmed that it wasn't, and follow-up call was arranged.'* Again, the panel identified a need for professional curiosity at this point. It is not unusual for victims of domestic abuse to find accepting agency calls difficult when a perpetrator is present. We do not know if this was the case, but had CGL followed up and explored this, it could have presented an opportunity for disclosure. This becomes especially pertinent with the benefit of hindsight, as we see Jessica drop out of contact with CGL from this point until she contacted them again at the start of September. In the intervening period she can be seen to be suffering some form of abuse on the timeline, which is explored in Multiple Disadvantages below, and is apparent at the end of June when Jessica is found in a concerning state, appearing to lack mental capacity having taken Diazepam and alleging sexual assault to the ambulance service.

xix. In August 2023 Jessica disclosed to CGL that she had *'used'* with some people from the rehab group. She requested online support to help her to avoid these triggers for using. She also disclosed using with '*a friend whilst attending DRR and they had gone back to her property and used drugs.'*

xx. The panel noted that these disclosure again presented opportunities to explore the nature of these relationships, specifically in the context of our awareness of the correlation between domestic abuse and substance use, with research finding that domestic abuse perpetration is common among men attending treatment for substance use in England.[39] This is critical awareness for substance use services who have opportunities to challenge those who cause harm (see Perpetrator Management below) in the context of gender-based violence against women.

xxi. It was the panel's view that not exploring the presence of domestic abuse with Jessica presented a missed opportunity to identify her as at high risk of harm and refer her to a multi-agency process.

xxii. CGL noted practice improvements to date including:

- Risk management and communication/ follow-up of risks.
- Updating internal case recording, review, transfer, allocation and service interruption (e.g. for hospital admissions) processes.
- Use of multi-disciplinary meetings for practice management.
- Improved joint working between CGL and Probation for clients in court mandated treatment; and, strengthened minimum attendance requirements for this cohort.
- The development of domestic abuse 'champion' practitioners.
- Mandatory attendance of staff at monthly safeguarding meetings (formerly optional).
- Awareness of the Respect helpline for those who cause harm.
- Further audit practices and 'learning from reviews' sessions are in hand.

[39] Gilchrist et al, Controlling behaviours and technologically facilitated abuse perpetrated by men receiving substance use treatment in England and Brazil. Drug and Alcohol Review, 36(1), pp52-63.

xxiii. Jessica disclosed abuse and relationship issues within health settings. For the purposes of brevity, a sample of examples has been used from across the chronology to make the panel's points regarding the importance of professional curiosity, safe/ routine enquiry and the risks of diagnostic overshadowing[40] for those experiencing co-occurring conditions.

xxiv. The GP practice attended by Jessica until 2022 knew that she struggled with her mental health and had made referrals for support around this as early as 2019. Despite Jessica concerns about disclosure, they did eventually become aware of her substance use as we see them flag her records for cautionary prescribing due to her risk of overdose. When Jessica started to experience homelessness, she registered with an Access Surgery. This is a GP surgery providing specialist care to patients facing homelessness or in temporary or emergency housing. The surgery provides full primary care services to its patients including GP and Nursing services, works in collaboration with CGL and hosts Drug Clinics. The team provides services at the surgery as well as via outreach.

xxv. Jessica predominantly saw her GP for prescribing related to her mental health and substance use. The panel noted key opportunities for professional curiosity/ safe enquiry at the practice in December 2023 and January 2024. In the former visit she asked for her lips to be checked as she believed she was being poisoned. Her GP recorded, *'I suspect she was under the influence of drugs again'*, but in January she requests emergency contraception for consensual intercourse, and in February for antibiotics for a human bite on her hand. Curiosity was displayed and support offered in relation to the bite. However, it was the panel's view that these represented an opportunity for the practitioner to be curious about who she felt might be poisoning her, whether she felt safe in a relationship and, given the bite, to make an onward referral for multiagency support based on professional judgement.

xxvi. From autumn in 2022 onwards Jessica disclosed assaults and her mental health and drug use appeared to spiral until January 2023. Between January 2023 and January 2024, she presented at the ED at CUHT[41] three times and on one

[40] Diagnostic overshadowing is a phenomenon in healthcare where a patient's symptoms are incorrectly attributed to an existing diagnosis (like a mental health condition or disability) instead of exploring other possible causes. This can lead to delayed or missed diagnoses of other medical conditions, potentially causing unnecessary suffering or even endangering the patient.
[41] Cambridge University Hospital Trust

occasion was taken to the ED at Addenbrookes Hospital by the police. On an occasion when she was seen by the LPS they recorded that she '*talked continuously about being gaslit by a man who said if she left the [temporary accommodation] she would be killed.'* (2023: ii) LPS also noted that a male friend was with her, who tried to claim pills that were in her possession and sell drugs in the staff restaurant. The IMR author recognises that there was no curiosity or routine enquiry regarding this overt disclosure or any observations of the man in her company. In the context of possible exploitation concerns, explored in Multiple Disadvantages below, this curiosity is an essential feature of safeguarding.

xxvii. The panel acknowledged CUHT's IMR author's observation that there is *'clear evidence in the record of Jessica being able to express her opinion and make choices which were listened to and respected by staff though they tried on numerous occasions to facilitate and encourage her to stay until she was medically fit for discharge.'* It is clear from the chronology that healthcare practitioners were compassionate and supportive towards Jessica, going above and beyond what was required of them at times.

xxviii. A Liaison Psychiatry Service (LPS) also operates within general hospital settings. This service sits under the remit of the CPFT[42] (secondary care services for those with mental health needs). Jessica was often referred to the LPS as her presentations were often mental health based. Most of these interactions are explored below in the Mental Health Services section.

xxix. However, there were instances of Jessica's possible domestic abuse experiences not being explored in both health services. The CUHT IMR author noted that in January 2024, *'the notes made numerous references to reports by Jessica that someone had been trying to drug her, about possible sexual assault and other concerns which could have been indicative of exploitation. However her dialogue was very muddled, and she had been brought in by the police who were requesting a mental health assessment so the reports she was making may not have been taken as seriously as they should have been.'*

[42] Cambridgeshire and Peterborough Foundation Trust

xxx. When speaking to the LPS Registrar,[43] Jessica gave her concern about her sexual health as the reason for attending the ED. She further described that her boyfriend could not look after her dog, *'as he has a drinking habit'*. Jessica was asked about drug use and her mental state, including suicidal ideation. She repeatedly asked to leave but was persuaded to remain overnight. The following day the Consultant Psychiatrist saw Jessica; she was more settled and less *'thought disordered'* but expressed her ongoing *'psychotic beliefs'* about people harming her or interfering with her environment. She described believing that she had been intentionally poisoned and then possibly sexually assaulted by her boyfriend. She mentioned that she felt she was being defrauded via her bank card, claiming it was the people at the bank.

xxxi. She was asked if she was safe to go home, at which point she said, *'Oh, he's lovely.'* The CPFT IMR author noted that, *'during a case review meeting [it was discussed] that the disclosure of rape was made amongst transient abnormal delusional and persecutory psychotic beliefs. However, [the registrar] recognised that Jessica was very vulnerable when under the influence and that what she described were very plausible possibilities of sexual abuse and these were not discounted as delusional. The psychiatrist sought her consent to refer her for sexual assault support which she declined.'* The psychiatrist did send, in line with good practice, details of the rape crisis service that Jessica could access.

xxxii. A lack of professional curiosity was also noted in Jessica's engagement with the CAMEO (specialist psychosis service) in February 2024 when she identified that her recent crisis could have been triggered by *'poor sleep and having had sex for the first time in years in December.'* During this time neither the CAMEO nor CRHTT (crisis team) service followed up on Jessica's disclosures of sexual assault whilst in the hospital.

xxxiii. The panel noted that not making further enquiries regarding the relationship and disclosures of abuse or failing to contextualise Jessica's responses within consideration of either her sense of safety to disclose or her determination to be at home, was problematic. It further noted that had these enquiries been made the potential risks faced by Jessica from Krzysztof, a well-known violent

[43] A registrar is a doctor who is training to become a specialist in a particular area of medicine.

perpetrator of domestic abuse, might have been uncovered, she might have been deemed high risk on the basis of professional judgement, and could have then been subject to a multi-agency response.

xxxiv. The IMR author for the CUHT noted that in 2023 the Domestic Abuse Policy was subject to review, bringing a range of departmental policies under one document for consistency, and that that work is ongoing regarding skills development for healthcare practitioners in areas such as routine/ safe enquiry. CPFT embedded routine enquiry into policy following the advent of the Domestic Abuse Act, 2021. Enquiry is contained in the first quality statement of the NICE Domestic Violence and Abuse Standards, 2016:

People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.[44]

xxxv. This standard is explored in the Health Pathfinder Toolkit[45] which offers two approaches to enquiry into domestic abuse. The first is 'routine' - all patients are asked, and the second is 'selective' – the presence of indicators prompts the question to be asked. It is Department of Health and Social Care policy that routine enquiry is undertaken in maternity, mental health and sexual health services because of the higher incidence of domestic abuse for these cohorts. Selective enquiry should be undertaken where routine enquiry is not. The toolkit contains extensive guidance on indicators and approaches to asking the question. It was the view of the panel that work should be undertaken to ensure that practitioners across both settings are asking the questions regarding domestic abuse as set out in their respective policies.

xxxvi. Jessica was also seen by the Probation Service and the IMR author noted that, despite the practitioner being sensitive to Jessica's needs and trying to work constructively in relation to her offending history, there was a lack of curiosity about relationships and that routine, policy-based domestic abuse checks did not take place. This was a missed opportunity to identify the extent of Jessica's risk of significant harm in the context of domestic abuse.

[44] NICE Quality Statement 1
[45] Pathfinder Toolkit, Standing Together et al. 2021 (pp98)

Multi-Agency Safeguarding

i. Cambridgeshire operates an 'integrated front door' approach which covers services that work across the county to manage the referrals received in respect of children, young people and vulnerable adults.[46] Jessica was referred to the MASH which is part of the front door methodology. The MASH is a multi-agency environment with full time involvement from Children's and Adult's Social Care, Police, Health, Education, Early Help, Domestic Abuse Services and a number of virtual partners such as Youth Offending, Probation, Fire Service and Housing. All core partners have signed an Information Sharing Agreement (ISA) which enables detailed information sharing as necessary. The purpose of the MASH arrangement is to enable timely and informed decisions about safeguarding concerns, ensuring a coordinated and effective response.

ii. In delivering this purpose the MASH process should achieve early identification of risks, improvements to coordination and collaboration, faster, coordinated and more effective responses to concerns, enhanced decision-making and improved outcomes for vulnerable people.[47] The benefit of this approach is endorsed by The Care Act, 2014. The approach should include assessment, information sharing and multi-agency planning to safeguard adults from abuse and neglect, ensuring that concerns are taken seriously, assessed promptly and addressed effectively.[48]

iii. If an individual does not consent to information sharing via MASH, this can only be overruled in the presence of a 'high' risk assessment based on vulnerability, risk and other safeguarding factors. Jessica was referred to MASH on more than ten occasions by police officers as they recognized her vulnerability; these referrals were generally in relation to episodes where police had attended in response to mental health crises, and/ or drug offending. Jessica was generally a 'no consent' referral into the MASH process.

iv. The Police IMR author noted that on one occasion in August 2023, a decision was made not to share information and called this *'questionable'* given Jessica's history, pointing out that it '*failed to reflect a person-centred and outcomes-focused approach.'*

[46] Cambs. County Council Website - Integrated Front Door & Early Help
[47] Multi-agency safeguarding hub, HMICFRS. 2023 [Accessed 8.4.25]
[48] The Care Act, SCIE [Accessed 8.4.25]

v. In July 2023, a policy decision made by the MASH Detective Inspector directed staff to remove interest in all mental health vulnerable adult investigations whereby consent was not obtained and where it could not be established if they were open to CPFT. The rationale for this decision was based on consultation with mental health colleagues regarding their policy decision to no longer accept referrals for persons not already open to them. The earliest mention of this policy change for Jessica was in September 2022 when the ARC responded to the referral out from MASH stating, *'the person related to this 102*[49] *is not open to any of our [hospital] teams. Due to a policy change, we are unable to process the alert in this instance and any future alerts where the person related is not open to any of our teams'* (2022: xxxv)

vi. The MASH staff were not privy to information relating to persons that were not 'open' to the mental health trust, so this police decision was an interim one, until such time as a recruitment process to appoint a mental health trust employee into the MASH was completed. During this interim period, the control room mental health practitioners (IMHT) were unable to accept referrals from MASH as there was no method of establishing whether that person was open to the service. This policy decision was revoked in January 2024 when the new employee was appointed whose role is to check if individuals coming through to MASH are open to CPFT. There is a noticeable gap for referrals for Jessica during this period. However, irrespective of this gap, the co-located mental health practitioner was still, at the time of writing, not offering additional accessibility for vulnerable service users when they are not open to secondary mental health services. Rather they were just checking whether the individual's case was open to secondary mental health services.

vii. The panel noted that the MASH process utilised for Jessica appeared to focus on assessment and information sharing only, and that the current MASH Information Sharing Agreement 2024 states that the purpose of the MASH is to bring together partner agencies to share information and *make decisions* about the safeguarding of children, domestic abuse victims, and adults at risk. The MASH is responsible for assessing, reviewing, and responding to internal and external safeguarding referrals ensuring appropriate sharing with partner agencies. It is also responsible

[49] Form 102 is the notification process tool

for collaborative working with partners to identify and initiate immediate safeguarding and investigative actions to protect vulnerable people includes, taking part in strategy discussions, professionals' meetings, and MARACs. A recent development is the new partner agency portal available on the Constabulary's website. It allows members of partner agencies to make reports directly to police, removing unnecessary demand on 101 services and the MASH to enable facilitation of contact between partners and the police which is less time consuming and more streamlined. It was the view of the panel that MASH leadership should use the learning from this review to reflect with MASH agencies on the importance of the strategizing and planning aims of the MASH setting in the context of the current ISA.

viii. The panel noted an example of good multi-agency practice in the availability of the JRV, an award-winning initiative whereby mental health practitioners attend police incidents with officers to better support those with mental health crises. Jessica was seen in this way on multiple occasions. However, as she felt her concerns were not heard (disclosures of assault and other incidents) she engaged with the practitioners less.

ix. The disclosure of being chased that Jessica made to the police was considered, along with prior disclosures she had made in the previous months, as an expression of her poor mental health and substance misuse, which impacted her engagement with mental health and police support. Her later arrest for possessing offensive weapons indicates that she was indeed afraid, which could either have been an expression of psychosis or of a fear for her safety that was based in reality, but was attributed to her mental health needs.

x. This type of diagnostic overshadowing of Jessica's voice was noted earlier in the report. When Jessica was arrested for carrying weapons, the police IMR author noted the records stating, '*The review concluded this incident was isolated with mitigating factors related to [Jessica's] mental health.' She was assessed by LADS [Liaison and Diversionary Service], who completed a holistic vulnerability triage and a suicide risk assessment in line with policy. Jessica is noted as telling the LADS practitioner that her main concerns were homelessness and loneliness. She was asked about relationships and spoke about her family but was not asked about domestic abuse specifically.'* She was offered and accepted a LADS

support worker to help her with accessing more community support. The support worker called her 3 times but was unable to get a reply. They then wrote to her asking Jessica to call them if she required ongoing support. Jessica did not reply and was discharged.

xi. In November she continued to say that she was being chased and was reassured by police. She was again frustrated about not being believed. In December she had multiple contacts with the police and there was a fire in her home, for which she was arrested. While under arrest she stated that she had been assaulted by travellers at a local park and had had her handbag stolen.

xii. The panel observed that there was a lack of curiosity as to whether Jessica was being exploited and abused by local drug gangs, which could have led to an NRM (National Referral Mechanism) referral. The grooming of vulnerable women and girls for the purposes of exploitation is a known phenomenon and drug gangs do engage men/ vulnerable men to act as 'Loverboys'[50] – we cannot know if this was Jessica's experience because the issue was not fully explored.

xiii. The NRM resulted from The Modern Slavery Act 2015 which came into force on July 31, 2015, consolidating previous legislation criminalising slavery and human trafficking and aiming to combat all forms of exploitation. Although we do not know if this mechanism applied, we do know that vulnerable women who are using substances problematically are vulnerable to commercial sexual exploitation. Agencies may fail to identify this risk if they have a bias to expect this to happen only to foreign nationals. The panel was of the view that consideration should be given to women in vulnerable positions, such as Jessica, and that the learning from this review should be used to raise awareness of these risks.

xiv. The police IMR author notes that Jessica increasingly demonstrated high risk, high harm behaviours which meant that she met the conditions under MARM (Multi-Agency Risk Management)[51] and that this may have been the most suitable forum to manage and progress her safeguarding needs, best interests and outcomes. The author notes that from a policing perspective, Jessica *'presented a danger to*

[50] This is a method of grooming vulnerable women and girls in the guide of a loving relationship often for the purposes of sexual exploitation and trafficking.
[51] Multi-Agency Risk Management Guidance, Cambs and Peterborough Safeguarding Partnership Board [Accessed 9.5.25]

herself, family, community and wider public including emergency workers. The inability of agencies to provide longer term support and interventions exacerbated her fragile state and deterioration of [mental health]. A collective and co-ordinated strategy and collective ownership may have proved more beneficial in terms of engagement and outcomes for [her].' The panel agreed that the MARM framework could have been considered for Jessica and awareness-raising of its use in these circumstances should take place in multi-agency partnership settings.

xv. The police IMR author notes that to improve processes and services to victims, Cambridgeshire Constabulary launched Project KAIZEN in April 2022, which provides guidance and support to the workforce relating to all aspects of public protection and safeguarding. Following a previous DHR, a simple "top ten" Supervisory Safeguarding Review guidance was introduced which reiterated that safeguarding is a continuous process throughout the investigation, with a requirement to re-assess and review regularly, and specifically at salient points.

Information-sharing

i. A key element of safeguarding, generally and in relation to domestic abuse practice, is that of sharing information in order to provide the greatest opportunity for risk management and support. MASH was a vital site of this for Jessica as she had not been identified as 'high-risk' for the purposes of a MARAC referral.

ii. Information sharing is a fundamental principle of the Coordinated Community Response methodology[52] - ensuring that risk management is known between agencies is fundamental to victim safety and perpetrator accountability.

iii. Information sharing between supporting agencies is also integral to the safe practice of individual agencies providing support. The panel noted the routine and effective collaborative practice between CGL and the Probation service, with regular conversations and updates taking place enabling the agencies to work in tandem in relation to Jessica's offending and substance use. As noted, however, no domestic abuse risks were identified so could not be held in scope.

[52] A CCR brings services together to ensure local systems truly keep survivors safe, hold abusers to account and prevent domestic abuse. What is CCR? Standing Together [Accessed: 20.4.25]

iv. The panel further noted that routine MASH referrals for Jessica were good practice, although the suspension of referrals in relation to mental health constituted a missed opportunity to understand the victim impact of a failure to identify abuse and the consequent escalation in suicidality risk.

Perpetrator Management

i. Identifying and responding to perpetrators of domestic abuse requires a multi-faceted approach focused on safety, support, and prevention. It involves recognising potential perpetrators, assessing risk, and responding appropriately, often through specialised interventions and referrals. The goal is to prevent further harm and promote positive changes in the perpetrator's behaviour.[53]

ii. Domestic abuse practice has been driven by victim-focused services, and we recognize on the policy landscape today that failing to identify and manage perpetrators of abuse creates an unequal landscape that places the onus of safety of the person being victimised.

iii. As previously noted, Krzysztof had significant vulnerability and risk factors for the perpetration of violence in intimate relationships. With regard to the use of substances and potentially other vulnerability factors, it is important to note that correlation does not equate to causation. By focusing on substance misuse rather than on the individual and his behaviour, we conflate correlation and causation and fail to place accountability where it belongs - on the individual's behaviour. We can see examples of this, for instance when Krzysztof described to CGL services in October 2023 that some substances brought out the *'damaging aspects of his personality'*. This presented a practice opportunity to engage with these beliefs and ensure that accountability was not deferred onto alcohol. The CGL IMR author noted that Krzysztof's disclosures should have led to exploration in 1-1 settings for enhanced risk management practice. This could have led to considerations as to whether Krzysztof was suitable to the group working sessions, especially as he may have established his relationship with Jessica in them.

iv. Krzysztof also described his former relationship as '*toxic'* – a misnomer that can create the fallacy that both parties are problematic in that dynamic. This ties in

[53] Responding to Perpetrators, The Drive Partnership [Accessed 8.4.25]

with a misapprehension on the practice landscape that *'bi-directional'* or *'mutual'* abuse is possible in a domestic abuse context. The panel observed that it is important for agencies to understand that this typology of domestic abuse was described by the originator, Michael Johnson[54], as a 'false' typology and that he cautioned us to understand that power will always be uneven, so we must ask ourselves, *'Who is doing what to whom and with what effect?'*. It was the panel's view that where counter-allegations are present it can be helpful for practitioners to understand the complexity of these in the context of domestic abuse. [55]

v. The panel observed good practice by CGL staff in making a child protection referral based on their knowledge of Krzysztof's background and awareness of his intent to see his daughter. It further noted the practice developments in progress at CGL that should assist with perpetrator accountability.

vi. Krzysztof was also regularly in contact with the Probation service throughout the period. He was known to have a violent offending history and problematic alcohol use which exacerbated this behaviour. The Probation IMR author noted multiple issues with Krzysztof's risk management. Firstly, a child protection referral was made too late, and the practitioner did not challenge Children's Services decision not to intervene given his ongoing alcohol use and further offending. The author noted that the practitioner was later subject to performance management and that an area of learning for the service is adequate management oversight where there are performance concerns.

vii. Secondly, the author noted a lack of curiosity regarding an incident involving visitors to Krzysztof's property that could have informed risk management plans. The author further notes that Spousal Assault Risk Assessment (SARA), the probation tool to assess risk posed by perpetrators of further abuse within an intimate relationship, was used problematically. SARA was completed in October 2023 for Krzysztof and there are some gaps in the assessment and inaccurate information that resulted in potential risk to future partners being underestimated. There is evidence of minimisation of his actions within previous relationships, as described above, as well as a previous assault on his mother in 2022.

[54] A Typology of Domestic Violence, Michael Johnson. 2008
[55] Counter-Allegations Guidance, SafeLives. 2024

viii. The IMR author further notes that a lack of contingency planning for either Jessica's or Krzysztof's entry into a new relationship meant that when Krzysztof disclosed, in January 2024, that he was in a relationship with Jessica, there was a small window of time in which to act. The panel noted the IMR author's statement that, due to service pressures, the local probation unit responsible for Jessica and Krzysztof's oversight was operating under the Probation Prioritisation Framework, meaning that some interventions were not delivered unless there was immediate risk. The panel observed that not identifying the risks presented a missed opportunity to make an adequate prioritisation.

ix. In a College of Policing evaluation of SARA and another tool SAM (stalking assessment), it states, *'While the training provided before implementation of the tools was viewed positively, participants felt it did not provide them with enough knowledge to complete the two risk assessment tools or use them effectively in their work. Offender managers had too many difficulties with the forms for them to feel there was benefit in using them. There was little consistency in the way offender managers completed the forms, and the risk ratings of offenders frequently differed between managers. Other barriers identified to effective use of SARA or SAM include the time commitment required to complete a SARA or SAM, the availability of information needed for their completion and offender managers feeling isolated and in need of more support.'*[56]

x. This is further supported by the report, published by the Justice Inspectorate, *'A thematic inspection of work undertake, and progress made, by the Probation Service to reduce the incidence of domestic abuse and protect victims'* (2023) in which it is identified that while 30% of people on probation are current or prior perpetrators of domestic abuse, only 28% of those on probation had been sufficiently assessed for risks of further domestic abuse, and 45% of the sample should have had access to an intervention but had not. Consequently HMPPS (His Majesty's Prison & Probation Service) published an action plan to drive improvements.[57]

xi. Information gathering would be impacted by the lack of curiosity identified above and it was also the panel's view that management oversight should be available

[56] Evaluation of using the SARA and SAM tools to assess and manage risk, College of Policing. 2021
[57] A response to: A thematic inspection of work undertaken, and progress made by the Probation Service to reduce the incidence of domestic abuse and protect victims, HMPPS. 2021

for the routine use of these tools to balance assessment oversight and that this review should be utilised to inform the delivery of a local action plan in line with national requirements.

The victim's wishes and feelings

i. In February 2021 Jessica advised CGL, with which she had recently become involved, that she wasn't sure if it '*was for her at the moment'*, as she believed that she needed '*intensive therapy*.' (2022: viii) She said that she hadn't received any bereavement support and was signposted to relevant charities.

ii. In May 2022 we see her desire to be free from drug use and the mental health issues she experienced when she presents at CGL stating she had two options, '*either call a taxi and go to her dealer or get a taxi to CGL and ask for help'* (2022: xxi). At this meeting she said she would like to go to a residential rehabilitation centre. She was told this was an option, but that they would need permission to speak with her GP. The panel noted that the option of rehab was never revisited with her, although it understood the complexities of engaging when someone is struggling to fully commit to a programme.

iii. However, Jessica clearly did not move far away from the idea of a non-dependent lifestyle; she described multiple attempts to self-detox and on one occasion in late May 2022, stated that she needed to be at CGL every day to achieve sobriety. She was offered daily group work and other methods of support along with bus fare refunds, which was noted by the panel as good practice. Her needs in relation to her clearly expressed desire to live a substance-free life are further explored in the Multiple Disadvantages section.

iv. The panel was concerned that Jessica's voice was hidden by presumptions about her mental wellbeing, substance use and/ or service configurations. In October 2022 Jessica telephoned the police stating that she was being chased and was hiding in a public toilet. On police arrival, her presentation was believed to be primarily due to substance misuse. Jessica was angry that professionals did not believe she was at risk of harm from others and that they believed that her experiences were due to her mental ill health and substance misuse; she therefore declined to engage with the mental health practitioner further and said she was going home.

v. In the summer of 2023, she continued to ask for opioid blockers and the CGL consultant did review and update her detox plan. She was advised, however, to continue to depend on psycho-social interventions for progress. She stated that she '*did not feel capable of addressing some of the underlying reasons for her substance misuse' with records noting that 'she was reassured that stability on OST would provide her with the capacity to do so at a later date.'*

vi. In September 2023 Jessica was not happy that she still had to visit the pharmacy on a daily basis and appeared agitated with CGL. This could have been for a variety of reasons, but the panel noted that in early October she tested positive only for benzodiazepines which indicates that she was still striving to self-detox. In October she had positive engagement with the women's group, speaking articulately about her need for purpose as a woman. The panel noted that CGL's implementation of women's groups was good practice in light of the vulnerability experienced by many of the women and Jessica's experience of meeting Krzysztof in this setting.

vii. The issue of her possible exploitation and trauma-responsive practice is addressed in Multiple Disadvantages below, but the panel noted that from this point on Jessica became less trusting of the police as her voice was not heard, when it is widely and increasingly understood that victims of DVA are the experts in their own experience whose voices need to be heard.

Multiple disadvantages

i. The Making Every Adult Matter (MEAM) coalition state that *'People facing multiple disadvantage experience a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives.'* Jessica faced all of the issues in this list, with these combined disadvantages rendering her, specifically as a woman, highly vulnerable to abuse and exploitation.[58] Disadvantage can also extend to intersectional system barriers, and Jessica's dependence on state welfare was an additional issue that reduced her ability to access the resources she required for her needs.

[58] Complicated Matters Toolkit, AVA. 2013

ii. In socioeconomically deprived settings, women with multiple disadvantages are rendered more vulnerable to exploitation and abuse cloaked in the guise of loving relationships and set within the context of risk management (i.e. the avoidance of worse harm through the acceptance of some harm).

iii. In working with women who experience this level of disadvantage it is essential that practice focuses across their needs, seeing them as a whole person and working without silos. There are some key areas of potential learning for agencies in a resource published by AVA in 2013.[59] This resource identifies the need to work collectively across the mental health, substance misuse and domestic and sexual violence experiences rather than in silos, and to offer patient and flexible support options. This is further reinforced by a 2024 Department of Levelling Up, Housing and Communities' report that identifies the need to:

- Improve service and practitioner capability and capacity to support women experiencing multiple disadvantage.
- Adapt or provide specialist housing-based interventions.
- Integrate or co-ordinate domestic abuse services with support for multiple disadvantage.
- Provide tailored, relational recovery support in safe spaces.[60]

iv. Cambridgeshire was an early adopter/ pilot area for the MEAM programme, having noted in the 2010 JSNA (Joint Strategic Needs Assessment) the need for services that could support those living with complexity. It has continued since that time and is currently known in Cambridgeshire as *Changing Futures*; this programme is a relationally-focused approach which understands the trauma-responsive importance of the work and is able to remain available to those living with multiple disadvantages and work on the basis of their experience, strengths and hopes for the future.

v. Changing Futures offers several approaches to creating better outcomes for the people it serves. The team coordinates services, offering a lynchpin to complicated multi-agency practice, and advocating/ connecting approaches by

[59] Ibid.

[60] Understanding domestic abuse interventions for women experiencing multiple disadvantage: A rapid evidence assessment. Department for Levelling Up, Housing & Communities, April 2024

centring the voice of the user. It has recently added a system coordinator specifically to work on the development of systemic practices and also to offer co-production and a trauma-informed practice network. They are currently developing Multiple Disadvantage Forums with multi-agency representation designed to identify and discuss those who might fall through the net because of systemic barriers; the aim is for this to include MASH staff which could be helpful for women like Jessica.

vi. The service is grounded in trauma-responsive practices, an essential component of such an approach. Trauma and shame competence are integral to working with those whose lives have been made complex by disadvantage. In undertaking work in a trauma-informed way the aim is to embed the principles of this practice throughout the work to better engage and serve vulnerable clients[61]; in working with shame competence, the practitioner aims to understand, identify, and constructively engage with shame, both in themselves and in others, especially as this is often bypassed, deflected or unconscious.[62]

vii. Addiction is often marked by a 'shame cycle' of dependence, i.e. a pattern of substance use to escape or avoid negative self-conscious emotions that paradoxically lead to increased shame related to being a person who is dependent on substances. This is evident in Jessica's comments that she is *'not a heroin addict'* and is not *'like them'* (2023: xxix). She also described in 2021 not wanting her GP to know about her issues and not wanting to join group therapy. This form of denial can create a dynamic where the individual minimizes the full extent of their issues as the shame cycle becomes a defense against conscious awareness and the consequent feeling of shame. Services can also reinforce shame in their practices, for example, in setting out goals to be attained, focusing on the problem rather than strengths and pathologising rather than normalising the human experience. David Bedrick refers to four ways in which practitioners become healing witnesses (as opposed to shaming witnesses) – by acknowledging the violation, empathising with the pain, expressing protection and validation and by radically believing the person's account.[63]

[61] These principles as described by SAMHSA are - Safety, Trust & Transparency; Peer Support; Collaboration & Mutuality; Empowerment, Voice & Choice and Recognising Cultural, Historical & Gender Issues.

[62] Shame Competence research article [Accessed 24.4.25]

[63] The Unshaming Way, David Bedrick. 2025 (pp18)

viii. With some services in this review noting resourcing issues, it is also important to consider the ability of services to remain responsive to shame and trauma when they themselves are in a resource-poor position. This builds in systemic defense mechanisms that are often about protecting the agency rather than the individuals. In this way we see that the system itself starts to become traumatised.

ix. The panel observed that Jessica was in a pattern of attempting self-detox/ failing to achieve this and clearly asking for more intensive therapy and residential support. These perceived 'failures' whilst still living with the pain of her trauma, can reasonably be assumed to have served to embed the shame of substance use, creating a classic shame cycle for her. CGL clearly practices in a non-shaming way, normalising addiction for its service users and working extensively to engage them in treatment options.

x. The panel reflected on the approaches taken by other agencies in relation to Jessica's co-occurring substance use and mental health needs. They acknowledged that resourcing issues do get in the way of good practice, but that the purpose of the review is to *'illuminate the past to make the future safer'*, so we should not suppress possible changes we could make because we are aware of a lack of resources.

Co-occurring conditions

i. CGL worked with Jessica regarding her substance use and is experienced in working with individuals who have the co-occurrence of both substance and mental health issues. She also had contact with mental health services regularly via the LPS and community-based services. In an admission in January 2024, the Consultant Psychiatrist acknowledged that community-based referrals were problematic due to the difficulty of engaging with her in the community.

ii. 'Hard to reach 'is a term commonly used for those people whom services find difficult to access. Today we understand that it is systemic barriers that generate these issues, and the panel was of the view that Jessica experienced some of these barriers. This is notable in her desire to attend CGL daily and in her need to have bus fares refunded to access the service as well as in services finding it difficult to establish and maintain contact with her through traditional methods,

such as phone calls and letters. For example, in September 2023 the REDS group wished to check if she wanted support in the group programme, but they were *'unsuccessful in contacting Jessica by letter or phone, so the referral was again closed until she made contact.'* Earlier in the year they had emailed regarding the group, asking her to be in touch within four weeks and, after sending an email reminder, closed the referral. The panel noted that more could be done to work with those whose lifestyles are such that they may not monitor emails and manage appointments effectively.

iii. It was the panel's view that Jessica experienced diagnostic barriers to accessing support too. On the multiple occasions that she spoke with LPS practitioners, the issue of her presenting as psychotic and delusional and whether this would 'wear off' as she sobered up was continually discussed. However, none of this resulted in adequate treatment for her mental health needs. Picking apart Jessica's primary need was a chicken and egg scenario in the face of such complexity, and it is recognised in research that a silo approach to issue management can be used to justify the transference of responsibilities around the system in the face of capacity pressures.[64] Coordinating services to work holistically in order to avoid re-traumatising and demoralising transitions is noted as best practice when working with multiple disadvantage. An opportunity to improve practice also exists in the development of shared treatment/ support plans with a lead professional being identified who can focus on the development of a safe and trusting relationship.[65]

iv. The Changing Futures coordination of services, using the MEAM approach, endeavours to address many of the issues raised in this section - coordinating, being trauma-responsive and person-centred, and advocating for help - all things that Jessica lacked as she navigated complex and overstretched systems whilst vulnerable and alone. It was the panel's view that the Changing Futures programme should be sustained for funding with ongoing awareness-raising strategies of the availability of this service across agencies.

[64] Systems change for people experiencing multiple disadvantage, Fulfilling Lives LSL Research and Learning Partnership. March 2022
[65] Ibid.

v. By the end of 2022, Jessica was homeless, had expressed feeling unsafe in temporary accommodation and was trying to stay at the hospital. She was asking for safety but afraid to talk about the sexual assaults she was disclosing. LPS recognised a pattern of increasing contact with emergency services and noted *'growing concerns over her expressing paranoid ideas, however the assessors were unclear if her presentation was a drug induced acute psychosis which might have resolved once the substances wore off, or an underlying psychiatric condition that would benefit from treatment'* (2023: xlvi). Options for admission were explored, but as there were no hospital psychiatric beds available, it was agreed that Jessica could stay in the ED overnight, which although not ideal was at least compassionate.

vi. As was the pattern, the following day she was *'seen to have improved'* and wished to return home. In accordance with practice, she was referred to CRHTT who made '*many attempts'* to contact her, with the CPFT IMR author noting they exceeded guidance but that without support and with ongoing substance use, her mental health could be seen to spiral throughout the month. She was offered Talking Therapies in Jan 2023, but no appointment was available till March.

vii. With the benefit of hindsight, it is possible to see how desperate Jessica was to be seen, heard and made safe. The panel was minded of two of her earlier wishes – intensive therapy and residential rehabilitation - asking itself what might have happened had those been provided? At this point Jessica's issues required more than the provision of trauma stabilisation; she was diagnosed with 'Opioid induced mental disorder' on a later visit to the hospital.

viii. As 2023 progressed, Jessica was proactive in her attempts to engage with CGL. She continued to struggle with maintaining OST use and continued trying to self-detox. By April she was subject to a court-mandated treatment order, which the panel noted to be effective in increasing the regularity of her engagement, and the police IMR author noted that other criminal justice measures could have been taken to disrupt her substance abuse through a focus on offending behaviour. As far as Jessica's mental state was concerned, this could have been a protective

mechanism with OST and CBT (Cognitive Behavioural Therapy) programmes being recommended for Opioid Use Disorder.[66]

ix. During her mandated treatment through the summer of 2023, Jessica was seen by the LPS, and they noted improvements to her wellbeing but that she was still describing a belief that she was being monitored by the police, although it was noted, *'that the intensity of her delusions had reduced since her last assessment.'* In November she was rejected for talking therapies as her needs were '*too high'* and was referred again to the REDS programme. At this point she was no longer subject to mandated treatment and, with the benefit of hindsight, a decline in her engagement seems to have correlated with escalating substance use and mental distress.

x. The panel observed that the systemic barriers that exist for those with co-occurring conditions were evident during Jessica detainment on a Section 136 (S136)[67] by the police in December 2023. As she was medically fit, they wanted to take her to the S136 suite to await a mental health assessment. The nurse in charge declined her due to her substance use and the associated risks and she was taken to the ED instead. The following day she dismissed concerns and was not deemed to meet the threshold for detention under the Mental Health Act. She was encouraged to engage with REDS. Two weeks later she was escorted back to the ED as she was behaving bizarrely and expressing paranoid ideas at her GP practice. The Consultant Psychiatrist noted that she was experiencing acute persecutory psychosis likely related to drug use, in line with prior admissions but further noted, '*there was reasonable evidence Jessica had a chronic psychotic illness over and above the acute presentation and the mental disorder appears to have been present to some degree for 12-15months.'*

[66] Drug Misuse and Dependence Guidelines, DHSC. 2017

[67] Section 136 allows the police to take someone to a place of safety without a warrant if all they appear to have a mental disorder, are in a public place, and/ or are in need of immediate care or control for their own or others safety. Before using section 136 the police must consult a registered medical practitioner, a registered nurse, an Approved Mental Health practitioner, occupational therapist or paramedic if practicable.

xi. Over the coming weeks, Jessica was in touch with both the crisis service (CRHTT) and CAMEO regarding her mental health crisis and possible psychotic illness respectively. The panel noted that on speaking with the CRHTT practitioner Jessica was recorded as describing that she went to hospital when she was *'in a state',* usually when she had taken drugs and people around her knew the state she was in. However, she also noted that she got in that *'state'* when she hadn't taken drugs, others did not notice and therefore she did not go to hospital.(2024: x) This was an indication that her possible psychosis was not only present when she used drugs; she was given crisis numbers to call as a result of this disclosure.

xii. Jessica continued to speak with CRHTT and was scheduled for an extended assessment with CAMEO. She disclosed ongoing substance use but had also agreed to and started to use Quetiapine – an anti-psychotic medication. The crisis team concluded that Jessica's work with CAMEO would enable *'diagnostic clarity, psychoeducation, and optimization of antipsychotics.'* They also noted the *'fixed delusions the CRHTT assessor believed may have suggested a diagnosis of schizoaffective disorder.'*

xiii. Jessica did not have an assessment booked with CAMEO until two weeks after this meeting, having cancelled three appointments. She said she was *'embarrassed'* about the *'delusional stuff' and* recognised that a lot of it had not been real. She felt the anti-psychotic medication was working for her but noted she remained mistrustful of CGL. She also noted having signed up for REDS and wishing to move away to *'get away from the people that she had previously used substances with.'* The record states that she declined a CAMEO assessment at this time. The nurse felt that her mental state had improved, that she was no longer in crisis and that there were reasonable plans in place. The panel noted that there was no record of these services communicating with one another, and that the practitioners should have contacted one another to check the other's intervention status.

xiv. The police investigation identified that Jessica and Krzysztof used a quantity of cocaine together around this time, had an argument and he left. Jessica was not seen by Krzysztof or her neighbours for nine days following this, at which point they contacted the police, who found her at home, deceased.

16. Conclusions

i. Jessica was a loving mother who experienced the death of a child which, over time, set the basis for later issues with addiction and a spiral into adversity. Her story is a cautionary one for agencies who may come into contact with individuals who experience a loss of this magnitude and go on to live with unresolved grief.

ii. As Jessica struggled with addiction and could no longer live with her family, she became increasingly vulnerable to abuse and exploitation. Consequently, at an addiction service she met a man whom her family saw control and abuse her. This abuse was largely hidden from agency view and subsequently the heightened risk of Jessica's suicide was not contextually considered.

iii. Jessica's children expressed their perspective on the relationship between Krzysztof and Jessica. They described controlling, prejudiced and abusive behaviours from Krysztof that caused Jessica to see less of her children in order to protect them. They described a classic dynamic of control, whereby the person causing harm isolates and controls the victim's situation in order to render them dependent on the abusive person. Jessica's multiple and intersecting needs created a barrier for agencies in seeing this dynamic and offers lessons in both identifying and understanding the risks that relationships of this nature pose, no matter how short.

iv. This barrier was marked by diagnostic overshadowing, whereby, Jessica's abuse was seen as an expression of her mental health and/ or substance misuse which led to a lack of curiosity, identification and subsequently multi-agency working.

v. Jessica spoke about ending her life on many occasions although she did not describe plans or intent to do so when these disclosures were explored with her. However, in the last few weeks of her life she was experiencing increasing mental health issues and had been through a period of trying to free herself from drug use to no avail. In this context the problematic nature of her relationship with Krzysztof intersected to lead to her acting on her thoughts and ending her own life.

vi. Recognition of the risks of suicide is paramount for agencies. However, it cannot be known if the outcome would have changed in this situation. Women living in Jessica's circumstances are some of the most vulnerable in our society and this review reminds us how important developing our ability to help those women remains.

17. Lessons to be learnt

i. Professionals must consider the profound impact that unresolved traumatic grief can have for those who experience this issue and strive to provide support that can resolve this emotional burden early. This is because it can create the circumstances in which disadvantage and vulnerability flourish.

ii. Professionals must use curious and creative practice to recognise the complexity that arises in identifying abuse where multiple disadvantages exist. This is because holistic approaches rooted in exploration and listening are essential to supporting recovery and stability.

iii. Professionals must be attentive to the risks of interpersonal violence and abuse for women living with multiple disadvantages, especially where there are issues that may overshadow hearing and exploring their voices. This is because opportunities for intervention, safety and change are lost when behaviours, statements and interactions are explained away by mental health, substance use or other issues.

iv. Professionals must stay attentive to suicidality as a complex area of practice, one which is dynamic and often unpredictable. Agencies must strive to develop their skill, curiosity and cognisance of the presence of these risks, using available guidance and practice to work openly with safety planning and eliciting understanding of the potential of harm.

18. Recommendations

Number	Reference	Recommendation	Agency
1	DA: viii	The Cambridgeshire Suicide Prevention Strategy renewal should incorporate the Suicide & DA Toolkit from Cheshire East in order to strengthen agency understanding of the connection between these issues.	Public Health
2	DA: viii/ MAS: xiii/xiv PM: iv V, W&F	The learning from this review should be used in the annual DHR/ DARDR learning event for the 16 days of action with specific reference to hidden harm, suicidality. MEAM practice and the updated MARM framework.	Cambridgeshire DASV Partnership
3	MDs: iv	Awareness of the Changing Futures programme should be renewed with MASH agencies with the aim of connecting MASH and the Multiple Disadvantages Forum.	MASH/ Changing Futures
4	MAS: vii	MASH practice should be subject to a learning review with multiagency partners reflecting on this review in the context of the purposes of MASH, specifically planning and strategizing	MASH strategic board
5		CGL should continue to develop practice and interrogation of key safeguarding risks with service users.	Change, Grow, Live
6	DA: xxv	This review to be used in safeguarding training and the risks of 'diagnostic overshadowing' reflected on at safeguarding meetings to enable raised awareness and professional challenge in future cases when working with those with co-occurring conditions and domestic abuse.	Integrated Care Board
7	DA: xxv	This review to be used in safeguarding training to improve	Integrated Care Board

		identification of domestic abuse and violence and awareness of an increased risk of suicide where domestic abuse is present when working with those with co-occurring conditions.	
8	DA: xxvi & xxiv	CPFT undertakes a review of clinical record keeping policy to ensure professional curiosity, family composition, and disclosures are documented.	CPFT
9		CUHT undertake a bulletin reminding practitioners of the need to undertake routine/ selective enquiry in line with policy for the identification of DVA	CUHT
10		This review to be used by CPFT in safeguarding training to improve identification of domestic abuse and violence and awareness of an increased risk of suicide where domestic abuse is present when working with those with co-occurring conditions.	CPFT

Appendix A – Terms of Reference

Cambridge Community Safety Partnership

Introduction

Following an agreement that the criteria for a Domestic Homicide Review (DHR) has been met and the Independent Chair has been appointed, the first stage of a DHR is the establishment of clear Terms of Reference (ToR). Guidance for setting DHR ToR is provided in Section 4, Paragraphs 40-42 of the Home Office Statutory Guidance for the conduct of DHRs.

Confidentiality

All agencies involved in the review are subject to a confidentiality agreement. It is each participants responsibility to ensure that adherence to this statement is maintained.

1. Background

1.1 In March 2024, police officers attended a from the Cambridgeshire Constabulary attended a Cambridgeshire address, following a reported concern for the occupant, Jessica. They found the victim deceased on the landing in the property with a large vertical cut on her left wrist. In the run up to her death Jessica had been in contact with police on two occasions in relation to domestic abuse from her partner, Krzysztof.

1.2 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, the case was referred to Cambridge Community Safety Partnership for the consideration of commencing a DHR by Cambridgeshire Constabulary.

1.3 The Partnership, in consultation with the County DASV Partnership, made the decision to commission a DHR, notifying the Home Office of this decision in March 2024. In accordance with established procedure the review was given a working title.

2. The Purpose of a DHR

2.1 The purpose of this review (as described in Section 2, paragraph 7 of the Home Office Guidance) is to:

a. establish what lessons are to be learned from the death 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.

3. The Focus of a DHR

3.1 Sec 2, Para. 8: Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions

3.2 Sec. 2. Para. 10: A successful DHR should go beyond focusing on the conduct of individuals and whether procedure was followed to evaluate whether the procedure / policy was sound. Does it operate in the best interests of victims? Could an adjustment in policy or procedure have secured a better outcome for the victim? This investigative technique is sometimes referred to as professional curiosity.

3.3 Sec. 2, Para.12: The rationale for the review includes ensuring that agencies are responding appropriately to victims of domestic abuse by offering and

putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The review will also assess whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.

3.4 In December 2016, the Government issued updated guidance on Domestic Homicide Reviews especially regarding deaths resulting from suicide. The guidance[68] states:

'Where a person took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.'

4. Scope of the review

4.1 Deceased: Jessica. DOB: (removed for confidentiality)

4.2 Boyfriend: Krzysztof. DOB: (removed for confidentiality)

4.4 Timeframe: 1st of January 2022– date of death

5. DHR Methodology - IMRs (See Sec. 7 and Appendix One of the Home Office Guidance about IMRs)

5.1 Independent Management Reviews (IMRs) must be submitted using the templates issued by the review chairperson. The deadline for the return of IMRs is the 7th of November 2024.

5.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Jessica and/ or Krzysztof in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with either party, and who is not an immediate line manager of any staff whose actions

[68] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised August 2013 Home Office revised again by 2016 guidance paragraph 18 page 8

are, or may be, subject to review within the IMR. Agencies required to submit an IMR are listed at **Appendix A**.

5.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

5.4 Each agency required to complete an IMR must include all information held regarding Jessica and Krzysztof during the timeline. If any information relating to Jessica as the victim, or Krzysztof as the perpetrator, or vice versa, of domestic abuse outside of the scoping period comes to light, that should also be included in the IMR. Given the complex circumstances of Jessica's life at the time of her death, her mental health and substance misuse issues specifically, it is requested that agencies include any background information that pre-dates the 1st of January 2022 start date that enables the Panel to understand issues that may assist in considering Jessica's vulnerability at the time of her death.

5.5 Information held by an agency that has been required to complete an IMR, which is relevant to the death, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Jessica and/or Krzysztof. If the information is not relevant to the circumstances or nature of the death a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

5.6 Any issues relevant to equality, i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

5.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel, and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the

Chair of Cambridge Community Safety Partnership. Panel membership is listed at **Appendix B.**

6. Specific Issues to be Addressed

6.1 Appendix One of the Home Office Guidance outlines the requirements for agencies' analysis of involvement. The following are given as examples of the areas that will need to be considered in agency IMRs, along with any further specific issues to the case. These will form the **Key Lines of Enquiry** expected to be addressed in the Analysis section of the Overview report (Page 37 – Home Office Guidance):

i. Were practitioners sensitive to the needs of Jessica and Krzysztof, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations? Did staff engage with available training?

ii. Did the agencies have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) or other risk management tools, conduct risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Jessica and/or Krzysztof? Did the agencies have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Jessica and/or Krzysztof subject to a MARAC or other multi-agency fora?

iii. Did the agencies comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?

viii. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

ix. Were senior managers or other agencies and professionals involved at the appropriate points?

x. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Jessica and promote her welfare, or the way it identified, assessed and managed the risks posed by Krzysztof? Was there an appropriate level of joint working between agencies? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xii. Were multi-agency working practices appropriate?

xiii. How accessible were the services to Jessica?

xiv. Were links between mental health, substance misuse and domestic abuse identified during any assessments or contacts with either individual?

xv. Were there any key vulnerability episodes in relation to Jessica's mental health, substance misuse or other domestic abuse before the scope of the review that could have afforded an opportunity for interventions that might have made Jessica's future safer?

6. Engagement with the family and community

6.1 While the primary purpose of the Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of Jessica and her family, both chosen and biological, and details of their involvement with the Review, are included in this.

6.2 Cambridge Community Safety Partnership, through the Independent Chair, are responsible for informing the family that a Review has been commissioned, and an Independent Chair has been appointed.

6.3 Primarily, this is in recognition of the impact of the death of Jessica, giving family members the opportunity to meet the Review panel if they wish and be given the opportunity to influence the scope, content, and impact of the Review. Their contributions, whenever given in the Review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process focus on the individuals in scope's perspectives rather than just agency views.

6.4 All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Chair will be the single point of contact with the family in relation to the Review in addition to any Police liaison officer, dependent on those proceedings.

7. Media reporting

7.1 In the event of media interest, all agencies are to use a statement approved and provided by Cambridge Community Safety Partnership.

8. Publishing

8.1 It should be noted by all agencies that the Review Overview Report will be published once completed, unless it would adversely impact on Jessica or her family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

8.2 The media strategy around publishing will be managed by the Review Panel in consultation with the Chair of Cambridge Council Community Safety Partnership and communicated to all relevant parties as appropriate.

8.3 Consideration should be given by all agencies involved regarding the potential impact publishing may have on their staff and ensure that suitable support is offered, and that staff are aware, in advance, of the intended publishing date.

9. Document Control

9.1 The two parts of these Terms of Reference form one document, on which will be marked the version number, author and date of writing/amendment.

9.2 The document is subject to change as a result of new information coming to light during the review process, and as a result of decisions and agreements made by the DHR Panel. Where changes are made to the document, the version number, date and author will be amended accordingly, and that version will be used subsequently.

9.3 A record of the version control is included in **Appendix A**.

Home Office feedback

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

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

Sarah Fines
Community Safety Team
Cambridge City Council
PO Box 700
Cambridge
CB1 0JH

05 June 2026

Dear Sarah,

Thank you for submitting the Domestic Homicide Review (DHR) report (Jessica) for Cambridgeshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 22nd April 2026. 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; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

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

On behalf of the QA 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	Jessica
COMMUNITY SAFETY PARTNERSHIP	Cambridgeshire
DATE REVIEWED BY QA BOARD	22nd April 2026
DECISION	Publish with amendments.
GOOD PRACTICE COMMENDED	• The analysis is comprehensive, evidence-based and clearly aligned to the Terms of Reference, with strong thematic structuring and effective use of research to contextualise findings. Good practice is appropriately identified, and there is clear recognition of complexity, multiple disadvantage and systemic factors. • The inclusion and placement of a family tribute, which helps humanise Jessica and maintain a victim-centred approach. • The inclusion of a "Through the Eyes of the Victim" section, which supports a stronger focus on Jessica's lived experience. • Clear recognition of intersectionality and multiple disadvantage and there is good consideration of sex, mental health and vulnerability in the context of domestic abuse
FEEDBACK FOR FUTURE DHRs	Please ensure the voice of the victim is clearly centred and evidenced across all sections.

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

4	**Condolences**	No amendments required.
5	**Confidentiality and Anonymity**	No amendments required.
6	**Terms of Reference**	No amendments required.
7	**Equality and Diversity**	• Please ensure the section clearly evidences how equality and diversity considerations informed the analysis, findings and recommendations, not solely contextual discussion. • Please outline more explicitly how Jessica's protected characteristics and multiple disadvantage impacted service responses and access to support, with clear links to identified learning. • Please ensure the narrative remains focused on the case, reducing general research detail where it does not directly inform the findings.
8	**Background Information**	• Please clearly outline the domestic abuse context, including the nature and impact of coercive control. Please also ensure the key risk factors are explicitly identified and that there is a clear distinction between family perspective and evidenced information.
9	**Combined Chronology**	Please ensure the chronology consistently distinguishes between factual events, professional opinion and information reported by others, and clearly signposts the points at which domestic abuse, suicidality, coercive control and multiple disadvantage intersected.
10	**Overview**	No amendments required.
11	**Analysis**	• Please strengthen this section by ensuring greater conciseness and sharper focus on the key learning, critical decision points and missed opportunities, particularly where risk escalation, domestic abuse indicators and multi-agency responses intersect. • Please ensure that the voice of Jessica is consistently centred, with clearer linkage between her lived experience, professional responses and the resulting outcomes.

12	**Conclusions**	Please strengthen this section by considering the key safeguarding learnings and critical missed opportunities more explicit, so that the conclusions clearly reflect the findings of the review and the basis for the recommendations.
13	**Lessons learnt and recommendations**	• Please ensure the lessons remain concise and focused on high-level learning, while still being clear and specific in intent. • Please strengthen the wording of the recommendations to ensure consistency and clarity, avoiding general phrasing and clearly stating what agencies are expected to deliver.
14	**Timescales**	Please confirm how the panel has provided assurance that learning has been progressed during the extended timescale.
15	**Involvement of family / friends / community**	Please outline more explicitly how the family's views have informed the analysis, findings and recommendations, beyond engagement activity.
16	**DHR contributors**	No amendments required.
17	**DHR Panel**	Please confirm and outline how the absence of Public Health representation was mitigated within panel discussions, particularly given the relevance of suicide in this case.
18	**DHR Author**	No amendments required.
19	**Parallel Reviews**	No amendments required.
20	**Dissemination**	Please outline how learning will be embedded, monitored and evaluated over time, not solely how it will be shared.
21	**Action Plan**	• Please strengthen this section by ensuring all actions are fully SMART. Please ensure that outcomes and success measures are clearly defined, timescales are consistent and realistic, and that progress descriptors (e.g. started, ongoing, completed) are applied consistently. • Please also ensure each action clearly demonstrates how it will lead to measurable improvements in practice.

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**	In the Executive Summary please ensure the key themes of domestic abuse, suicidality, multiple disadvantage and diagnostic overshadowing, are clearly articulated, alongside the critical missed opportunities. Please also ensure the voice and lived experience of Jessica are centred.