Cumberland Community Safety Partnership

DOMESTIC HOMICIDE REVIEW

Under Section 9 of Domestic Violence Crime and Victims Act 2004

OVERVIEW REPORT

In respect of the Death of Jo in February 2022

Report by Bridie Anderson

Independent Chair and Author

February 2025

LIST OF CONTENTS

Tribute

Jo's father describes her a being a 'dream child', a really good kid who never argued and did not seem to have any troubles.

Jo was really into her fitness and played hockey and practiced kickboxing.

She was an incredibly talented artist, and she loved to draw, creating some highly skilled sketches and renderings which her father still treasures.

Jo had a huge love of animals, especially dogs and their company brought her a lot of joy.

Jo was and always will be so dearly loved and is missed every day.

1. PREFACE

1.1 This Domestic Homicide Review is being conducted in accordance with Section 9 of the Domestic Violence Crime and Victims Act 2004.

1.2 Jo is not the real name of the person who died in Cumbria in February 2022; the pseudonym was chosen by her family to safeguard her identity.

1.3 The Cumberland Community Safety Partnership Domestic Homicide Review Panel would like to express its profound condolences and sympathy to Jo's family and friends. Jo's family accepted invitations to participate in the review.

1.4 Jo's death met the criteria for conducting a Domestic Homicide Review under Section 9 (3)(a) of the Domestic Violence, Crime, and Victims Act 2004.

1.5 The Domestic Abuse Act 2021 defines domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if —

a.) A and B are each aged 16 or over and are personally connected to each other, and
b.) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following —

Physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to acquire, use or maintain money or other property, or obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Definition of "personally connected" - For the purposes of this Act, two people are "personally connected" to each other if any of the following applies —

They are, or have been, married to each other; they are, or have been, civil partners of each other; they have agreed to marry one another (whether or not the agreement has been terminated); they have entered into a civil partnership agreement (whether or not the agreement has been terminated).

1.6 The Home Office guidance on Domestic Homicide Reviews states that where a victim took their own life (suicide), or there is an unexplained death 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. Reviews are not about who is culpable.

2 INTRODUCTION

2.1 This report of a Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Jo, a resident of Carlisle, prior to the point of her death on 21st February 2022.

2.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before Jo's death, whether support was accessed within the community and whether there were any barriers to accessing support.

2.3 By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

2.4 Jo was 28 years of age at the time of her death and was White British.

2.5 The Domestic Abuse Related Death Review is being conducted in accordance with Section 9 of the Domestic Violence Crime and Victims Act 2004.

2.6 The review considered agency's contact/involvement with Jo and her partner Lilith from August 2019 to February 2022. The reason this date range has been chosen is because it marks the year that Jo returned to live in Carlisle from Leeds.

2.7 The key purpose for undertaking DARDRs is to enable lessons to be learned from deaths where a person is killed or dies by suicide as a result of domestic violence and/or abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2.8 The narrative of this review seeks to articulate the life through the eyes of Jo by talking to those around her including family, friends, and professionals. This has helped reviewers to understand Jo's reality; to identify any barriers she faced to reporting abuse and learning why any interventions did not work for her.

2.9 The review seeks to explore everything with an open minded approach and understand the context and environment in which professionals made decisions and took (or did not take) actions. This includes, the culture of the organisations, the training the professionals had, the supervision of these professionals and the leadership within agencies.

2.10 This review aims to go beyond focusing on the conduct of individuals and whether procedure was followed, to evaluate whether the procedure / policy was sound, fit for purpose and operated in the best interests of victims.

2.11 This review has utilised the investigative technique sometimes referred to as professional curiosity. It is a thoroughly inquisitive approach, not seeking to apportion blame but identify learning needed.

3 TIMESCALES

3.1 This review began on 16th June 2022 and was concluded in February 2025. Whilst it is hoped that Reviews, including the Overview Report, be completed where possible within six months of the commencement of the review, this was not achievable in this case.

3.2 The reasons for the delays in this case relate to the need for a criminal investigation being identified at the early stages of the DARDR process. This resulted in the arrest of Lilith and other enquiries involving friends and family and agencies who had contact with Jo and/or Lilith.

3.3 This presented a period of delay to the progression of the review, as did a second review of the criminal investigation and need for an additional Police IMR, which was shared with the Chair and panel on 26.07.2024. The final panel meeting was held on 11.10.24.

4 CONFIDENTIALITY

4.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms agreed with the family are used in the report to protect the identity of the individuals involved.

Subject	Pseudonym
Deceased	Jo
Deceased's partner/ex-partner	Lilith

4.2 Any relevant addresses will be referred to only in general terms to protect the anonymity of those involved.

5 TERMS OF REFERENCE

5.1 Full Terms of Reference can be found at **Appendix 3**, inclusive of the reflective questions put to the panel members and IMR authors. The key lines of enquiry are listed below. Jo's family were advised of the terms of reference suggested and provided the opportunity to feedback on their content.

5.2 Individual Practice: how effective were agencies in identifying and responding to the needs and risks faced by the victim? Reflective Questions considered by panel and IMR authors:

5.3 What knowledge your agency had about the relationship between the victim and the alleged perpetrator?

5.4 What needs did your agency identify for either individual and how did your agency respond?

5.5 What specific support was made available to the victim as a result of her repeat domestic abuse involvement?

5.6 What opportunities were there to engage and refer over mental health issues and how was mental health considered/responded to in the context of domestic abuse?

5.7 What opportunities were there to engage and refer over substance misuse issues and how was substance misuse considered/responded to in the context of domestic abuse?

5.8 How were decisions made, and actions taken by agencies to reduce risk and prevent harm?

5.9 If domestic abuse was not known about, how might your agency have identified the existence of domestic abuse from other issues presented to you? For example, were there policies and procedures for direct or routine questioning and how well were they implemented in this case?

5.10 What barriers to engagement did agencies face and how did they seek to overcome these barriers?

5.11 How did agencies recognise and respond to issues of equality and diversity for either individual?

5.12 Was there any evidence of unconscious bias in the assessments, decisions or services delivered?

5.13 How effective was record keeping?

5.14 How effective was management oversight?

5.15 Did resource issues impact upon services offered?

5.16 How the Covid-19 pandemic impacted upon agencies' responses?

5.17 Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals' needs? Reflective Questions considered:

5.18 How roles and responsibilities were understood, and multi-agency protocols adhered to.

5.19 Was there a shared ownership and approach?

5.20 How effective was the co-ordination of services.

5.21 How effective was communication, information sharing and sharing records?

5.22 How effective was escalation between agencies?

5.23 Can you identify areas of good practice in this case?

5.24 Improving services: What lessons can be learnt to prevent harm in the future?

5.25 What recommendations are you making for your organisation and how will the changes be achieved?

5.26 What system-wide, multi-agency recommendations do you consider need to be made?

6 METHODOLOGY

6.1 On notification of the domestic abuse related death, all relevant local agencies were contacted. Agencies were asked to secure their files if contact with either Jo or Lilith was confirmed.

6.2 A scoping meeting was held on 16 June 2022, chaired by Bridie Anderson. As a result of this meeting, the following agencies were identified as possibly having information on the family:

- North Cumbria University Hospitals Trust (NCUHT);
- Clinical Commissioning Group (CCG);
- Ambulance Service;
- Carlisle City Council;
- Children's Social Care and Education Directorate;
- Victim Support;
- Cumbria Constabulary;
- LetGo;
- Riverside;
- Cumbria and Lancashire Community Rehabilitation Company;
- National Probation Service (NPS)

6.3 All agencies who had contact with Jo have submitted a chronology. Those agencies with direct contact have also supplied an Individual Management Review (IMR).

6.4 Previous Domestic Homicide Reviews were also examined. This ensured lessons identified in those reviews had been implemented, and learning disseminated across the partnership. Cumbria has had 4 previous DHRs.

6.5 The overview report is an anthology of this information.

7 INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

7.1 From the outset, the Review Panel decided that it was important to take steps to involve Jo's family.

7.2 Jo's next of kin were her parents who were contacted by the Chair were provided with details of the Review process and a copy of the Home Office leaflet detailing what a Domestic Homicide Review seeks to achieve.

7.3 The family had the help and support of specialist police family liaison officers from Cumbria Constabulary and were provided with details of specialist advocacy service, AAFDA.

7.4 The terms of reference were shared with the family to assist with the scope of the review, and they were invited to meet the Chair and provide input to the Review process to help brings Jo's voice to the fore.

7.5 The family have been updated regularly and have provided a tribute to Jo as part of this review.

7.6 The family have reviewed the draft report in private with plenty of time to do so and have the opportunity to comment and make amendments if required.

7.7 Consideration was given by the panel to involve Jo's partner/ex-partner and the alleged perpetrator, Lilith. It was agreed that she would be contacted by the Chair in order to provide her perspective on Jo's life and her relationship with her.

7.8 Contact was made with Lilith by the Chair, who spoke with her via telephone in October 2023. Lilith was happy to speak with the Chair and offered her information on the period of Jo's life preceding her death from her perspective.

7.9 Consideration was given to approaching friends, work colleagues, neighbours and wider community. However, it was not possible to identify any other contacts who could be approached.

7.10 Due to Jo and Lilith being in a same sex relationship the panel commissioned an input from an independent LGBT+ specialist practitioner and consultant in order to ensure the panel considered the review through the lens of an individual from that community.

7.11 The panel would like to thank Jo's parents for their contributions over the period of this Review and acknowledge the strength this took whilst grieving the tragic loss of their much loved daughter.

8 CONTRIBUTORS TO THE REVIEW

8.1 The following agencies made contributions to this DARDR:

Organisation/Service	Contribution
Cumbria Constabulary	Panel member, Chronology, IMR
Cumberland Community Safety Partnership	Information
Westmorland and Furness Council	DARDR coordination and management
Probation Service, Cumbria	Panel member, Chronology, IMR
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)	Panel member, Chronology, IMR
Victim Support	Panel Member, Chronology, IMR
Recovery Steps (formerly 'Unity')	Panel member, Chronology, IMR
Eden Medical Group (GP)	Panel member, Chronology, IMR
Temple Sowerby (GP)	Panel member, Chronology, IMR

Safeguarding Adults, Cumbria County Council	Panel member, Chronology, IMR
North Cumbria CCG	Panel member, Chronology, IMR
Safeguarding, North Cumbria CCG	Panel member, Chronology, IMR
North Cumbria Integrated Care (NCIC)	Panel member, Chronology, IMR
Department for Work and Pensions	Panel member, Chronology
Carlisle City Council (Housing Services)	Panel member, Chronology, IMR

9 THE REVIEW PANEL MEMBERS

9.1 The following staff represented their respective agency on the Review Panel:

Name	Role	Organisation
Clare Stratford	DHR Coordinator	North Cumbria Community Safety Partnership
Alison Goodfellow	DHR Lead/ Assistant Safer Communities Manager	Westmorland and Furness Council
Hayley Bishop	Area Planning Manager, Community Development Team Public Health, Customer & Community Wellbeing	Cumberland Council
Sheona Duffy	Acting named nurse	CNTW North Cumbria (mental health services) Integrated Care NHS Foundation Trust.
Dr Stephanie Siddle	GP, Wellbeing and Safeguarding (W&S) Lead	North East North Cumbria Integrated Care Board
Sarah Place	Senior Operations Manager	Victim Support
Amanda Boardman	Named GP safeguarding	NHS NORTHEAST AND NORTH CUMBRIA ICB
Peter Astbury	Safer Care Lead	Safer Care CNTW
Helen Crozier	Senior probation officer	Probation Service Cumbria
Molly Larkin	Safeguarding Designate Nurse, IMR reviewer	North Cumbria CCG
Sarah Edgar	DHR SPOC	Cumbria Constabulary
Becky White	Area Manager	Recovery Steps
Lucy Reed	Service Manager / Safeguarding Lead	Recovery Steps
Rachel Armstrong	Service Manager	Recovery Steps Cumbria
Gemma Qi	Safeguarding Advisor, IMR author	North Cumbria Integrated Care (NCIC)

Bharati Dwarampudi	Advanced Customer Support Senior Leader, Cumbria & Lancashire District	Department for Work and Pensions
Katy Driver	Advanced customer support lead for Cumbria and Lancashire	Department for Work and Pensions
Tammie Rhodes	Head of housing & homelessness & Designated Safeguarding Officer	Carlisle City Council

9.2 All members of the panel and authors of the IMR's have complete independence from any subject in this review. Following careful consideration by the Review Chair and the Panel, it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview.

9.3 The panel met a total of 7 times; 16th June 2022, 14th September 2022, 23rd January 2023 (LGBT+ training input), 9th May 2023, 9th June 2023, 9th August 2023, 11th October 2024.

9.4 Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

10 AUTHOR OF THE OVERVIEW REPORT

10.1 Bridie Anderson was commissioned by North Cumbria CSP to independently chair this DARDR and author the Overview Report. Bridie successfully completed the 'Conducting a domestic homicide review: online learning' course from the Home Office and the 'AAFDA DHR Chair Training' in July 2021.

10.2 Bridie is/has been commissioned as an Independent Chair and Report Author for a total of 7 DARDRs across the UK since completing her training.

10.3 Bridie is currently commissioned by specialist domestic abuse charity ESDAS to provide service manager support, multi-agency training, MARAC attendance and Chairing. Bridie regularly completes IMRs and chronologies for DHRs and SARs in Surrey on behalf of ESDAS. These have included deaths by both suicide and homicide.

10.4 Bridie is former police officer having served across two different forces before leaving the service in 2020. For the last 8 years of her service with Surrey Police, Bridie was the Surrey Police 'Force Advisor for Domestic Abuse, Stalking & Harassment'.

10.5 This role allowed Bridie to develop a range of specialist skills, training and qualifications in the complex and challenging area of Public Protection. It allowed opportunities for Bridie to work closely with numerous statutory agencies and NGOs to better understand a 360-degree perspective of domestic abuse, the experience of victims and the behaviour of perpetrators.

10.6 Bridie was the substantive panel member for Surrey's DHRs/SARs, representing Surrey Police.

10.7 Bridie is a qualified and practiced Family liaison Officer (FLO) having worked in this role with Hertfordshire Constabulary, supporting bereaved families in an investigative role for both traffic and crime fatalities in several tragic cases.

10.8 Bridie is a trained DASH RIC Risk assessor/trainer, Stalking Risk Profile Risk Assessor, Mental Health First Aider and MARAC Chair.

10.9 Bridie has not worked for any agency involved in this Review and is fully independent of, and has no connection to, the Cumberland Community Safety Partnership.

11 PARALLEL REVIEWS

11.1 A criminal investigation into an offence of 'Coercive and controlling behaviour in an intimate or family relationship', contrary to Section 76 of the Serious Crime Act 2015, was opened in June 2022 by Cumbria Constabulary, with Lilith identified as a suspect and Jo as the victim. This investigation was finalised with a result of 'no further action' on 23rd April 2023.

11.2 Following some new information coming to light through the review process, the criminal investigation was re-opened by Cumbria Constabulary in December 2023 and concluded with the same result in February 2024. An updated Police IMR was received by the Chair/Panel in July 2024 which included information from this reinvestigation.

11.3 A Coroner's inquest into Jo's death was due to take place in August 2022, pending the outcome of the police investigation mentioned above. This inquest was adjourned pending completion of the Domestic Abuse Related Death Review, and a date is yet to be set for the inquest to be held.

12 EQUALITY AND DIVERSITY

12.1 The Equality Act 2010 means that it is against the law to discriminate against someone because of their:

- Age,
- disability,
- gender reassignment,
- marriage and civil partnership,
- pregnancy and maternity,
- race,
- religion or belief,

- sex
- sexual orientation.

12.2 These are known as protected characteristics. In this Review the relevant protected characteristics include **age**, **sexual orientation and sex**.

12.3 Sex is a relevant characteristic in the Review as Jo was a female who it is believed may have died by suicide. She also identified as a lesbian and was just 28 years of age at the time of her death. Lilith was the same age as Jo.

12.4 Within this Review there is uncorroborated information which suggests Jo may have been pregnant at some stage during the period analysed, yet this pregnancy was not completed and details surrounding it are lacking. It is mentioned here as a protected characteristic, whilst reader caution is advised due to the inability of the panel or family members to verify or refute the information.

12.5 In a survey of data from 12 months '*Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021'*[1] 90% of suspected suicide victims were female and nearly three quarters (72%) of suspected victim suicides were aged under 45 years old. Within the same data set just 3% of victims were recorded as being LGBTQ+.

12.6 An article named '*Suicidal thoughts, suicide attempt and non-suicidal self-harm amongst lesbian, gay and bisexual adults compared with heterosexual adults: analysis of data from two nationally representative English household surveys*' was published in 2024 and identified a heightened risk of past-year suicidal thinking and lifetime non-suicidal self-harm amongst people who identified as bisexual or as lesbian/gay compared with heterosexuals.

12.7 This review therefore seeks to examine whether these characteristics presented any barriers to Jo accessing services and whether service delivery was impacted.

13 DISSEMINATION

13.1 Whilst key issues identified by the review will be shared appropriately, the report will not be disseminated until clearance has been received from the Home Office Quality Assurance Panel.

13.2 The IMRs will not be published. The DARDR report will be made public, and the recommendations will be acted upon.

[1] https://assets.publishing.service.gov.uk/media/6124ef66d3bf7f63a90687ac/Domestic_homicides_and_suspected_victim_suicides_during_the_Covid-19_Pandemic_2020-2021.pdf

13.3 The content of the report and executive summary is anonymised in order to protect the identity of the victim and their family members, staff and others, and to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR).

13.4 The report will be produced in a form suitable for publication after any Home Office approved redaction has taken place.

13.5 The family remain in consultation with the Chair to ensure that any key dates do not coincide with publication of this report.

13.6 Below is a table listing the recipients of the review report.

Name	Role	Organisation
Hayley Bishop	DHR co-ordinator	Cumberland CSP / Cumberland Council
Sarah Joyce	Service Manager Safeguarding Adults	Safeguarding Adults, Cumbria County Council (now Cumberland Council)
Sarah Edgar	DC, DHR SPOC	Cumbria Constabulary
Kate Allen	Safeguarding	North Cumbria CCG
Helen Crozier	Senior probation officer	Probation Service Cumbria
Gemma Qi	Safeguarding Advisor	North Cumbria Integrated Care (NCIC)
Tammie Rhodes	Head of Homeless Prevention & Housing Services	Carlisle City Council (now Cumberland Council)
Louise Cavanagh	Domestic and Sexual Abuse Business Coordinator, Cumberland Safeguarding Hub and Children Social Care	Cumberland Council
Dr Stephanie Siddle	GP, Wellbeing and Safeguarding (W&S) Lead	North East North Cumbria Integrated Care Board
Sarah Place	Senior Operations Manager	Victim Support
Kelly Marsden	Named Nurse for Safeguarding Adults	North Cumbria Integrated Care (NCIC)
Mary-Claire Telford	Strategic Lead for Domestic Abuse	Cumberland Council
Jo's mother and father[2]	Parents	N/A
David Allen	Cumbria's Police, Fire and Crime Commissioner	The Office of the Police, Fire and Crime Commissioner
Coroner Margaret Taylor	HM Coroner	HM Coroners Service (Cumberland Council and Westmorland and Furness Council)
Nicole Jacobs	Domestic Abuse Commissioner (DAC)	Domestic Abuse Commissioners Office

[2] Key dates not to publish have been explored with Jo's family, as well as the need for any additional support.

14 BACKGROUND INFORMATION (THE FACTS)

14.1 Jo lived in Cumbria with her girlfriend / ex-girlfriend Lilith at the time of her death, having moved back to the area from Leeds in August 2019 following the breakdown of a previous relationship. She originally moved in with her mother upon her return and then to Lilith's later that same year.

14.2 Jo had been struggling for years with mental health difficulties and alcohol misuse and was under the supervision of the National Probation Service (NPS) for offences of driving whilst over the prescribed limit of alcohol.

14.3 Jo and Lilith were known to Cumbria Constabulary for domestic call outs and their relationship had been discussed at MARAC[3], however this was with Lilith as the victim and Jo as the suspect. The first police report indicating that Jo and Lilith were known to each was in October 2019 when Jo was arrested for drink driving and Lilith was in the car.

14.4 Jo had made numerous requests for help from services with her alcohol misuse, poor mental health and due to experiencing suicidal thoughts throughout her short life.

14.5 Jo was dual registered with two different GP practices; Temple Sowerby, which will referred to as GP1 and Eden Medical Group which will be referred to as GP2.

14.6 On the evening of 12th December 2021, Jo left the address she shared with Lilith and was not seen alive again. She sent a text message to Lilith later that evening saying that she was 'waist deep in water'.

14.7 On the 14th December 2021, two days later, Lilith reported to the Police that Jo was missing. A high risk missing person investigation was commenced by Cumbria Constabulary. Tragically, Jo was found deceased several months later on 21st February 2022 by a member of the public in marsh land.

14.8 A post mortem was carried out on 23rd February 2022. This showed that Jo had a level of alcohol in her blood which was likely to have caused some impairment to her motor and cognitive function.

14.9 The cause of death determined by the consultant pathologist was 'cold exposure and drowning and alcohol consumption'. Due to the passage of time between Jo's death and the post mortem, it was difficult to interpret an exact cause of death more precisely.

14.10 This Review is being undertaken into Jo's death as it is considered to meet the criteria on the basis of disclosures of domestic abuse Jo had made to her probation officer and primary health care professionals.

[3] Mult Agency Risk Assessment Conference; is a meeting where information is shared on the highest risk domestic abuse cases. https://safelives.org.uk/about-domestic-abuse/domestic-abuse-response-in-the-uk/what-is-a-marac/

14.11 Jo's girlfriend Lilith was interviewed as a suspect Cumbria Constabulary in July 2022 and again in December 2023 on suspicion of using coercive and controlling behaviour towards Jo; she was released without charge and the investigations were filed.

14.12 The Home Office guidance on Domestic Homicide Reviews states that where a victim took their own life (suicide), or there is an unexplained death 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. Reviews are not about who is culpable.

14.13 This review seeks to understand the experiences of Jo through her eyes and identify areas of learning or development needed for agencies, either solely or collectively. This will then inform meaningful and actionable recommendations, agreed by all agencies which may help prevent a future death.

15 CHRONOLOGY

15.1 **This section of the report explains the background history of Jo's life, prior to the timescales under review stated in the terms of reference, to give context to her story.**

15.2 Jo was originally from Cumbria but had lived away from the area for several years. Her parents separated when she was 15 years old and her father went on to have a child, Jo's half-sister, with his new wife. Jo also had two older half-brothers from her mother's previous relationship, both of whom live abroad.

15.3 Jo had described herself to professionals as having had a complicated childhood, with her parents regularly falling out and refusing to be in the same room as each other, eventually separating. She recalled feeling like she was positioned as "the go-between" with her separated parents, sharing notes that they would want to pass to each other.

15.4 Jo lived in Portugal with one of her half-brothers for a year after turning 18, before returning to live in the UK.

15.5 In her late teens/early twenties Jo started to experience problems with her mental health, this would present with low mood, and she would use alcohol to help her to cope.

15.6 When questioned directly by doctors at GP1 Jo was often guarded in her responses and there were limited disclosures to them about any past trauma and how it had impacted her.

15.7 Jo's mental health challenges seemed to escalate around the time when she was preparing to leave home to go to university. In 2017 there was a query about

whether or not she had ADHD[4]; She presented with low mood and anxiety and was started on the antidepressant, Sertraline by GP1. It was also noted at that time that she had started to use alcohol to help her to cope with stress.

15.8 In 2018, while at University, Jo presented again with mental health issues and alcohol abuse. This time she was started on another antidepressant, Fluoxetine.

15.9 Jo had separated from a girlfriend she had been with when she was living in the Leeds area, prompting her return to Cumbria in 2019. Jo moved in with her mother upon her return, then her father before later moving in with Lilith, a girl she had recently met and formed a relationship with.

15.10 When she returned to Cumbria from Leeds her mental health appeared to have deteriorated. This was evidenced by her involvement with the mental health crisis team and Unity[5], the substance abuse service at that time.

15.11 Jo had previously had intimate relationships with both men and women and had expressed wanting to become a parent at some point in her life.

15.12 Jo was incredibly talented at art and created some beautiful and highly accomplished drawings. She was also passionate about physical fitness and enjoyed kick boxing and hockey.

15.13 Jo battled with alcohol addiction and suffered from poor mental health throughout her short life and had reached out for help numerous times before her death.

15.14 In **February 2019** Jo self-referred for mental health support through GP1. Three days after this Jo was sent a letter from the mental health support service (First Step[6]) as she had not engaged with them since her self-referral 10 days previously.

15.15 On **01.03.19** at 20.52 hours Jo presented at Pontefract A&E with a cut to her forearm stating it was caused during a hockey match. An appointment was made for her to attend the plastic surgery department 10 days later on 11.03.19, but Jo did not attend.

15.16 On the **04.04.19** Unity (Drug and alcohol recovery service) sent a letter to Jo discharging her from their service.

15.17 **The review seeks to examine in detail Jo's life between the point of her return to Cumbria in August 2019 and her death in February 2022. The following paragraphs provide a detailed narrative chronology of these events.**

[4] https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/
[5] https://fid.cumberland.gov.uk/kb5/cumberland/directory/service.page?id=DmSQS4ZJUe8&adultchannel=1_1
[6] https://www.cntw.nhs.uk/services/nctalkingtherapies/

15.18 **13th August 2019** Eden Medical Group (GP2) receive new patient registration for Jo. The record clearly documents basic new patient registration details including the fact that Jo had an 'alcohol consumption of 21 units'.

15.19 **18th August 2019** Jo calls 111 as she was feeling suicidal, an ambulance was arranged to attend to her.

15.20 **19th August 2019** Jo rang 111 from her car while sat outside her father's address in Appleby. Jo had recently split up with her partner in Leeds and come back to Cumbria with her possessions in her car. Due to a previous falling out with her father, Jo said she could not bring herself to knock on the door. Jo admits she had thought about checking the train times and stepping in front of a train but then rang 111.

15.21 The 111 service contacted Cumbria police who attended and located her. Jo's father had stated he was unable to have Jo in his house, so Jo's mother agreed that she could stay with her. Whilst with Jo the police helped her contact the Single Point of Access (SPA) line for mental health crisis support.

15.22 Jo reported during the call with the crisis clinician that her suicidal ideation had passed. She said planned to stay with her mother and may self-refer to Talking Therapies (then 'First Step') for treatment of her anxiety and low mood if she remained in the area. (She had previously self-referred and undergone treatment with the service in 2018.) Crisis and contingency planning were discussed with Jo during this call.

15.23 A referral was made to the Crisis Team following the incident above and Jo was triaged and subsequently accepted for home based treatment for assessment of her mental health, stabilisation and safety planning.

15.24 The crisis clinician stated that Jo had reported psychotic symptoms, and these were explored with no evidence of psychosis found, and no major mental illness detected.

15.25 GP2 received a notification from the Mental Health Practitioner at ALIS[7] regarding Jo, this referral included a very well documented assessment and plan, coded in her health records as "Auditory Hallucinations" and "Depressive episode", "alcohol abuse".

15.26 **21st August 2019** The home based treatment completes a face to face visit with Jo, who reported emotional dysregulation since adolescence and explained that she used alcohol to manage difficulties, binge drinking episodically. She said that she self-harmed intermittently (every two months, by making superficial cuts to her arms).

[7] https://healthwatchwestfurn.co.uk/services/access-and-liaison-integration-service-alis-east-cumbria-carlisle-ca1-3sx

15.27 An Alcohol Use Disorders Identification Test (AUDIT[8]) was completed with Jo where a score of 34 was recorded. (The AUDIT range of possible scores is between 0 to 40, so Jo scored high on this range. A score of 20 and over can be indicative of alcohol dependence, a moderate to severe alcohol use disorder.) Jo reported that her contact with Unity had been helpful previously and agreed to self-refer.

15.28 **22nd August 2019** Jo again called 111 reporting feeling low in mood and having suicidal thoughts; she was taken to A&E by ambulance. Jo was called by GP1, and she said she had been in touch with the mental health crisis team and had been drinking heavily again. She said that she had walked along the railway track before deciding to seek help by calling 111. She agreed to re-start her medication which she had been prescribed.

15.29 In a face to face visit with a crisis clinician, Jo reported reduced alcohol consumption and plans to discuss recommencement of antidepressant medication with her GP1 but requested a review with a Consultant Psychiatrist regarding her diagnosis.

15.30 **23rd August 2019** In face to face consultation with a Consultant Psychiatrist Jo reported daily suicidal ideation, with some planning, but was regretful of her recent actions. Diagnosis and treatment options were shared with Jo; her diagnosis was recorded as: *'Adjustment disorders with mixed anxiety and depressive reaction in background of chronic induced depression. Mental and behavioural disorders due to use of alcohol dependence syndrome. Emotionally unstable personality trait. Consultant Psychiatrist review to support psychoeducation and understanding of Jo's difficulties. Treatment plan shared with GP.'* There is no evidence from either GP1 or GP2 records that they received any treatment plan from the Consultant Psychiatrist on or after this date.

15.31 **25th August 2019** The home based treatment team crisis clinician visited Jo. Strategies to help improve her mood and coping were discussed. A further appointment arranged for two days later, on 27th August, but Jo did not attend, the same occurred on 28th August.

15.32 **29th August 2019** The crisis clinician conducted an unannounced visit to Jo's address, but she declined to meet with them, saying she was busy, so a future visit was planned for two days' time.

15.33 **31st August 2019** Jo cancelled the planned visit with the crisis team, reporting reduced suicidal ideation. A further appointment was scheduled.

15.34 Lilith states Jo moved in with her in September 2019, she was living with her ex-partner at the time so for a period, the three women were all living together.

15.35 **2nd September 2019** During a home visit from the crisis clinician, Jo described her previous relationships, problems within which she attributed to her increased alcohol use. Jo said she did now feel able to avoid unhelpful coping strategies with

[8] https://assets.publishing.service.gov.uk/media/6357a7af8fa8f557d85b7c44/Alcohol-use-disorders-identification-test-AUDIT_for-print.pdf

support from her family and reported that her suicidal thinking had reduced. Further appointment made for two days later.

15.36 **4th September 2019** Jo did not attend a planned appointment with the crisis team.

15.37 **10th September 2019** A call was held with Jo and crisis clinician and following agreement from the multi-disciplinary team, Jo was discharged from the crisis team. A letter was sent to that effect to both Jo and GP2. GP2 records indicate this letter was received this on the 16th September 2019.

15.38 **18th September 2019** Jo was engaging with Unity and reportedly reducing her alcohol intake. She was advised that her blood tests were however indicative of drinking too much and this was in turn having a negative effect on her blood cells and liver.

15.39 **6th October 2019** Jo was arrested for driving a motor vehicle whilst over the prescribed limit of alcohol following a road traffic collision in Appleby. Lilith was front seat passenger at the time and is the first incident recorded by Cumbria Police where the pair were known to associate.

15.40 Jo was investigated by Police for driving whilst over the prescribed limit but was subsequently released with 'no further action' being taken against her as she had a similar case pending from North Yorkshire. An exit risk assessment was completed with Jo upon her release from custody where she confirmed she had issues with poor mental health, physical ailments and alcohol misuse. Jo did not make any disclosures of domestic abuse or homelessness.

15.41 **11th October 2019** Jo phoned 111 for help as she said she was struggling with her alcohol addiction and self-referred to the Crisis Team reporting a resurgence of suicidal thoughts but no plans or intent. She stated that she had not taken her prescribed medication as she had left this at her mother's home and was now staying with a friend. She was advised to register with a GP in Carlisle and continue the antidepressant medication she was prescribed.

15.42 Jo reported to the crisis team that she was engaging with Unity but drinking one bottle of wine daily on a reduction plan. Records state that any further crisis team support was not indicated, and so the self-referral was closed.

15.43 **14th October 2019** GP1 tried to call Jo back following her call to 111 on 11.10.19 and eventually gets through in the late afternoon. Jo said she had stopped taking her medication but agreed to re-start it. She said that she was currently living in Carlisle and not speaking with her family in Appleby; she was advised to register with a GP practice in Carlisle.

15.44 **26th October 2019** Jo self-referred to the Crisis Team but did not respond to the call back from a clinician**.**

15.45 **27th October 2019** Attempts were made by the crisis team to contact Jo, but she did not respond. The risk was reviewed in multidisciplinary team and plans to continue to attempt contact with Jo were agreed.

15.46 **28th October 2019** A GP appointment at GP1 was requested by Jo, and one was arranged for the following day.

15.47 Jo was contacted by the crisis clinician for telephone triage. Jo reported experiencing low mood since an argument with her mother following her drink driving charges. She reported being abstinent from alcohol and in receipt of support from Unity. She reported she had not yet registered with a local GP but planned to do so, to access a sicknote.

15.48 Jo and the crisis clinician agreed for the crisis clinician to book a GP registration appointment and share details of the contact with Jo with Unity; the referral was then closed. Multidisciplinary agreement was reached for Jo's discharge from Crisis and details of the contact were shared with Jo's GP2 and Unity.

15.49 **29th October 2019** Jo did not attend the arranged GP1 appointment, stating this was due to transport issues, so it was rearranged for 01.11.19.

15.50 **1st November 2019** Jo did not attend her GP1 appointment, enquiries were made with the Access and Liaison Integration Service (ALIS) who stated Jo was no longer under their care. A message was left with the Community Mental Health Team by GP1.

15.51 **21st November 2019** Jo attended a housing drop in advice session at 15.30 hours. She stated that her local connection was Eden District Council (as she was from Appleby), and she went to University in York before coming to Carlisle in August, staying with either friends or her partner. She stated she could not afford the lodging fees being asked of her and disclosed that she had alcohol issues which were causing problems, so she was attending Unity to get help.

15.52 Jo disclosed a history of self-harm and suicidal thoughts, saying the last time was two months earlier when she was walking on a railway line. The housing officer discussed reconnection options; Jo confirmed she could continue to stay with a friend short term.

15.53 The Housing Officer was going to contact Eden District Council and refer Jo to supported accommodation; advice was given to Jo regarding Choice Based Lettings (CBL) registration once Jo's Universal Credit (UC) claim was live, Jo had an appointment with the DWP the following day (22.11.19). Jo was advised to contact the housing officer once the benefit claim was active or if her circumstances changed.

15.54 At 17.00 hours that same day the council are informed of a person outside the civic centre slumped by the bin, this turned out to be Jo. She appeared to be under the influence of alcohol as she was difficult to rouse. As she stood up she stumbled and

hit her head on a concrete planter; council staff contacted an ambulance who took her to hospital.

15.55 **22nd November 2019** Jo self-referred to the Crisis Team at 2am and when spoken to by a clinician at 8.41am she reported that she was staying with her friend. She said that she was experiencing suicidal thinking following alcohol use the previous evening, but she was no longer suicidal on rising that morning. She reported that she was continuing to engage with Unity.

15.56 **26th November 2019** Jo's GP1 tried to contact her to discuss her blood test results and a sick note but could not reach her, so a message was left asking her to call back.

15.57 **6th December 2019** Carlisle City Council housing called Jo who stated she wished to return to her mum but hadn't spoken to her family in a while; she asked if the housing officer would contact her mum for her. They report that several attempts were made by the housing officer to contact Jo's mum via phone call and text messages and that Jo's mum left a voicemail after receiving text stating she would call back, but no call was subsequently received. Several further contact attempts were made but all were unsuccessful.

15.58 Jo's Mum says that she did not receive these calls. She believes that housing may have called another number.

15.59 **11th December 2019** Jo's GP1 received a letter from Jo's father, outlining his concerns for her current mental health problems and alcohol consumption. As Jo was a capacitated adult, no information was provided to her father by GP1. There is no record of any action taken in relation to this letter, and the next record of Jo in GP1's system relates to an administrative call being made to Jo, unanswered so message left, requesting she update them regarding her current.

15.60 **3rd January 2020** Jo was sentenced to a 12 month Community Order with Unpaid Work and Rehabilitation Activity Days (RAR) for the offence of Drink Driving. Initial assessment by probation identified Jo as a victim of domestic abuse as her Index offence occurred when she had driven to Leeds to collect her belongings as ex-partner was threatening to throw them out on the street. This assessment also highlighted Lilith as Jo's new partner.

15.61 Jo described this as a new relationship and stated that there was some 'control issues', i.e. Lilith would check through her phone. Jo also indicated that she would have preferred to have her own accommodation but struggled due to COVID-19 and finding somewhere herself to live. From the onset of her involvement with probation the recognised risk assessment tool OASys identified Jo as both a perpetrator and victim of domestic abuse.

15.62 Jo reported to her Probation Practitioner that she had commenced a relationship with Lilith very quickly at the start of the COVID-19 pandemic. Jo had intimated that she would not be in a relationship with Lilith if she had her own place to live.

15.63 **13th January 2020** Jo self-referred to 'First Step' (IAPT[9]) for support with her low mood, an 'opt in' request was sent to Jo. GP1 was made aware.

15.64 **14th January 2020** Jo was arrested for theft as she was suspected of having stolen some alcohol. Whilst in custody Jo stated that she was struggling from a recent relationship breakdown which occurred in North Yorkshire, had lost her job and house and was struggling with anxiety and depression. Jo denied thoughts of self-harm or suicide but disclosed that she had self-harmed in the past.

15.65 Jo stated she was staying at an address in Carlisle but said her home address was in Appleby. A safeguarding report was submitted by Police for further support to be provided to Jo, and this was shared with Adult Social Care. Jo informed the Police that she had been in touch with First Steps but was yet to hear back from them.

15.66 **17th January 2020** Adult Social Care social worker contacted IAPT regarding a referral, an IAPT practitioner confirms Jo had been notified to opt in and arrange treatment.

15.67 **20th January 2020** Jo completed telephone assessment with IAPT practitioner. Jo reported that she attended Unity for support with alcohol use. She explained that she was completing Community Service with Probation supervision and was in receipt of support from Step Change for financial difficulties. She requested support for anxiety and depression. Jo was placed on the waiting list for Cognitive Behavioural Therapy. Crisis and contingency planning were discussed with Jo and GP1 informed.

15.68 Jo also attended an appointment with her Probation Services Officer (PSO) that day at the Women's Centre, she was allocated to the female only unpaid work group. Jo did disclose her history around suicidal thoughts and self-harm, and these were noted on her record.

15.69 **28th January 2020** Jo contacted 111 stating that she was homeless and feeling suicidal, after being in an 'abusive relationship'. The 111 operator called the police who located Jo outside a supermarket in Carlisle. Jo stated that she had a verbal disagreement with Lilith over her alcohol consumption resulting in Lilith asking her to leave and saying she wanted nothing further to do with her.

15.70 Jo stated told police that it was a verbal disagreement only and reported no other abuse. The summary of the argument that Jo provided to officers was that Lilith has accused her of drinking alcohol with Jo denying that was the case. Jo stated she was homeless and asked for a lift back to Appleby.

15.71 Officers transported Jo to Appleby and assisted with calling the SPA Line along the way. The SPA line stated they would call her back the following day. Jo then asked

[9] The Improving Access to Psychological Therapies (IAPT) programme provides psychological therapies to adults in the community with depression, anxiety and medically unexplained symptoms. Now known as Talking Therapies.

Police that she be returned to Lilith but was left in Appleby after completing a DASH RIC[10] they assessed as Standard.

15.72 Jo called her PSO to inform them she had been taken to Appleby as she felt 'unsafe due to her 'partner being abusive'. The PSO completed a Police intelligence check upon receipt of this information

15.73 Lilith was visited by Police who stated that she was frustrated by Jo's alcohol consumption and the fact that she was not contributing towards the bills. A safeguarding report was recorded and finalised at source due to being assessed at Standard risk of serious harm.

15.74 Jo spoke with a Crisis Clinician at 00.58 hours following her contact with the Police. She reported that she had had an argument with her partner, following an accusation of alcohol use and she had left the house and called emergency services as she was unable to get to her mother's home. She denied having a mental health crisis. Multidisciplinary agreement for discharge from Crisis. Information pertaining to this contact were shared with GP1 and Unity.

15.75 **29th January 2020** Jo saw the crisis team due to her ongoing problems with alcohol consumption.

15.76 **30th January 2020** Court date for North Yorkshire Police offence of driving over prescribed limit of alcohol. At this hearing Jo is disqualified from driving.

15.77 **31st January 2020** Jo called 111 due to experiencing poor mental health.

15.78 **February 2020** Lilith states she bought a house with her friend, and her, Jo and the friend all lived in together until the friend moved out. Jo was expected to pay £350.00 towards bills.

15.79 **11th February 2020** Jo attended an appointment with probation. The PSO reviewed the incident, which occurred on 28.01.20 when Jo was taken Appleby by Police, with Jo and looked at alcohol use and engagement with mental health services. Jo confirmed she was waiting for a First Steps appointment. This probation appointment had originally been planned for 04.02.20 but there had been some confusion, hence the delay from when original incident took place.

15.80 **13th March 2020** CCC housing receive an online self-referral form from Jo seeking advice as she was staying with friends after a non-violent relationship breakdown and wanted housing advice.

15.81 **19th March 2020** CCC housing officer made several attempts to contact Jo following her self-referral 6 days earlier, but did not manage to speak with her. Due to no successful contact being made the case was closed on 02.04.20.

[10] Domestic Abuse, Stalking, Harassment and Honour Based Abuse Risk Indicator Checklist; https://www.dashriskchecklist.com/

15.82 **15th May 2020** Jo did not respond to attempts to plan Cognitive Behavioural Therapy appointments and was therefore subsequently discharged by the IAPT practitioner following assertive efforts to engage her in treatment. Jo's GP was informed of discharge from the service.

15.83 It was around this time that Jo and Lilith's dogs had their litter of puppies.

15.84 **7th August 2020** Jo attended A&E due to a laceration over her eye, GP1 were made aware.

15.85 **3rd September 2020** Jo registered as a patient with the Eden Medical GP Practice (GP2) and a text was sent to Jo advising her that her registration was complete and naming her new GP there. No mental health/Safeguarding concerns were raised from the registration forms.

15.86 **15th September 2020** Jo calls GP1 regarding her low mood and a sick note is issued for her**.**

15.87 **17th September 2020** Jo self refers to the crisis team but does not respond to the crisis clinician's attempts to contact her.

15.88 **18th September 2020** Jo engaged in telephone triage with the crisis clinician. She reported some depressive mood and anxiety symptoms and requested a reintroduction to medication. Jo was encouraged to seek support from her GP for antidepressant medication. Jo reported previous non-engagement with Unity but said she planned to self-refer. Jo denied being in a current mental health crisis, so no further intervention was planned. Jo said she had supportive family and specifically mentioned her father and step sister as being protective factors for her.

15.89 **23rd September 2020** Jo sees the crisis team due to her deteriorating mental health, GP1 was informed.

15.90 **25th September 2020** A 'removal from practice' letter was sent to Jo from the GP1 as she was living in Carlisle and therefore out of their area.

15.91 **25th December 2020** For Christmas day Jo and Lilith had been invited to spend the day with Jo's mum, Lilith had been invited to spend the day at her own mother's, but without Jo. As such the couple agreed to spend the day at their own home together. However, Jo later informed her mother that Lilith had left her alone at home and gone to her mum's without her. Jo's mum describes her as seeming upset around this time, drinking more excessively and just not seeming herself. Between Christmas and New Year Jo disclosed that Lilith had assaulted her, she sent her mother a photograph of herself with an injury to her lower lip stating, *"This is what's going on in the house."*

15.92 **2nd January 2021** Jo's initial Community Order for drink driving was completed. Probation records indicate Jo attended and complied with the requirements of this order.

15.93 **6th February 2021** An appointment was made with Jo for a 'Recovery Steps[11]' assessment on 07.06.21 at 10am, 4 months' time.

15.94 **16th April 2021** Jo asks GP1 for an appointment due to struggling with depression. She is seen the same day and discloses low mood and binge drinking alcohol; she agrees for a referral back to First Steps to be made and a follow up appointment with the GP in 3 weeks' time.

15.95 **5th May 2021** Jo has a call with GP1 and reports that she feels more settled and had stopped drinking. She was advised to call back if she needed to discuss anything again.

15.96 **13th May 2021** Jo was due for a cervical screening test at GP1 but did not attend.

15.97 **30th May 2021** A member of the public reported seeing a car driving erratically prompting a police response. Police sighted the vehicle and found the driver to be Jo, despite her initially providing false details. She was found to be driving whilst over the prescribed limit of alcohol and arrested. Jo was later charged with several driving offences, including driving whilst disqualified and was bailed to attend court on 26.07.2021.

15.98 A risk assessment was completed in custody with the liaison and diversion (L&D) team where Jo confirmed issues with depression but denied issues with substance misuse or domestic abuse.

15.99 The police custody record shows that Jo said she lived with her partner of two years who was 'supportive'. She stated her relationship with her parents was strained at times and she felt that she was a disappointment to them. Jo denied any issues with substances or alcohol.

15.100 When questioned about the amount of alcohol she had consumed the previous night she said she had been drinking wine, and she felt life was stressful at the moment. She did not go into any detail about this when asked.

15.101 Jo agreed to access further support from L&D on her release from custody. A leaflet was provided to Jo with L&D contact details and other numbers she may find useful. L&D agreed to contact Jo's GP; this was sent to GP2. Jo was referred to L&D Interim case management for emotional support.

15.102 **31st May 2021** Lilith reported Jo to the Police as a missing person. Jo had sent Lilith a number of text messages indicative of self-harm or suicide. Lilith and Jo' parents went out looking for her. Lilith reported that Jo had sent her messages saying, "*this is the end of the road for me*", and that she "*does not have the mental strength anymore*", and "*I can't stop crying*".

[11] https://www.waythrough.org.uk/find-support-near-me/recovery-steps-cumbria/

15.103 A request for information regarding contact with Jo sent to Crisis clinician by Police, as she had been reported as a missing person. Proportionate information was shared.

15.104 Jo was found at 04:30 hours the following morning in a nearby park. She told police that she was upset about various things that had happened recently, that she had been arrested for drink driving which she felt embarrassed about and didn't want everyone to think she was a bad person, so she needed some time alone to clear her head. She said she was suffering anxiety and depression and had started taking medication about 8 weeks previously. She had been missing a total of 14 hours.

15.105 **1st June 2021** GP2 has a telephone consultation with Jo at **16.07 hours**. Jo explains that she had been directed to the surgery by the custody and liaison team. She said it was complicated as she had been living between Carlisle and Appleby and was used to seeing a GP at Temple Sowerby surgery (GP1). She said she was on her 8th week of taking fluoxetine 20mg, had been missing for 24 hours, picked up for drink driving that day".

15.106 GP2 documented that currently Jo was safe with friend, and asked for contact details and safety nets regarding mental health follow up. The GP then follows up the contact with a text stating she would call "next Tuesday" (08.06.21).

15.107 Jo contacted Crisis Team at **18.30 hours** reporting continued difficulties with low mood, anxiety and alcohol use. She planned to self-refer to Unity and self-referred to First Steps. Crisis agreed to refer to Lighthouse for additional support whilst awaiting drink driving charges which she reports is a current stressor.

15.108 The Lighthouse by Carlisle Eden Mind is an evening crisis support service, providing a calm, safe environment for people to visit when they are experiencing a mental health crisis, feeling unsafe or finding it hard to cope[12]. Jo denied being in any acute distress, and a discharge from the Crisis Team was agreed.

15.109 Jo was encouraged to self-refer to Unity and Jo and her GP were sent a letter to report her discharge from Crisis Team. Referral to Lighthouse completed.

15.110 Lilith contacted Crisis on behalf of Jo at **19.41 hours** reflecting concern as Jo had consumed two bottles of wine and was alcohol dependant. Lilith reported that she has previously taken Jo to A&E however Jo had refused to be seen. It was agreed that a referral to Unity would be completed on Jo's behalf. Crisis and contingency planning were discussed.

15.111 **2nd June 2021** Jo called GP1 for support due to mental health problems; she says she had spoken to the crisis team, but they were not helpful, so she wanted to see her GP. The same day Jo's mother called GP1 as she was also concerned about Jo's mental health.

[12] The Lighthouse | Carlisle Eden Mind | Crisis support (cemind.org)

15.112 **3rd June 2021** Jo has a phone call with GP1, and she discloses that she has not stopped drinking alcohol but is taking her medication. She expressed that she wanted to stop drinking. The GP increased the SSRI[13] antidepressant medication dosage and agreed to contact Unity and the Crisis team that day.

15.113 Lilith referred Jo for Crisis Intervention. Jo does not respond to the clinician's contact however on contact with Lilith, Jo did speak with the clinician for triage. Jo reported continued alcohol use and distress. A face to face appointment was arranged for the following morning, and Jo was asked to abstain from alcohol prior to assessment. Referral to Unity was completed by Crisis Clinician.

15.114 **4th June 2021** Jo's father contacts GP1 to express that he is very worried about Jo's current well-being.

15.115 Jo contacted the Crisis Team at **09.41 hours** reporting she was physically unwell and unable to attend face to face assessment, further contact agreed later the same day.

15.116 At **10.40 hours** the crisis team have further telephone contact from Jo reporting she is unlikely to feel well enough to attend for face to face review at all during the day. It was therefore agreed that Jo would contact Crisis back and be re-triaged when she felt able to attend for assessment.

15.117 Multidisciplinary agreement made for a discharge from Crisis for Jo. Details of the contact were shared with GP1.

15.118 **5th June 2021** Jo contacted the Crisis Team to report that she has self-referred to Unity with a planned appointment, but feels she is going through alcohol withdrawal. Jo discussed her symptoms, and she was advised to contact her GP or attend A&E should symptoms develop. Crisis and contingency planning discussed. Details of the contact were shared with GP, unclear which practice.

15.119 GP2 received a 111 report which was limited in terms of the history provided; the 111 reports tend to be more of a 'tick box list' of what is or isn't present rather than a narrative. It stated that Jo had reported worsening mental health and was referred to A&E.

15.120 No evidence of A&E attendance at that time and the GP2 was not sure if 111 were arranging this or if they were relying on Jo making her own way there.

15.121 **7th June 2021** Jo had a phone call with GP1, she said she was seeing Unity who planned to start her on a medication called Acamprosate[14] (medication to help reduce alcohol cravings).

15.122 Jo had a planned review with Unity but did not attend and calls made by doctor to Jo went unanswered. Unity identified that Jo's current alcohol use was suitable for the brief intervention pathway. Concerns regarding her poor mental health were noted.

[13] https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/ssri-antidepressants/overview/

[14] https://cks.nice.org.uk/topics/alcohol-problem-drinking/prescribing-information/acamprosate/

A plan was agreed that a worker would attempt to make further contact and flag any inability to contact or presenting risk. Unity shared a letter with GP2 regarding the planned detox for Jo.

15.123 **8th June 2021** Jo had a call with the crisis team and discusses her anxiety and depression.

15.124 At **14.48 hours** Jo has her appointment with GP2 as planned from last consultation on 01.06.21. Records indicate that Jo was "feeling and sounding much better", “engaging with Unity and on medication.” The GP agreed a further plan for Jo to continue taking her medication and she would review again in 6-8 weeks.

15.125 **14th June 2021** Jo requests a letter from GP1 for court which confirms her current medication, note in GP1 records states that Jo ‘seems stable at present’.

15.126 **21st June 2021** Lilith reported Jo as missing following an argument. Lilith stated that Jo was suffering with alcohol misuse and had self-harmed by cutting her arms. Jo had already been missing for 24 hours prior to being reported by Lilith due to the fact that ‘Jo had done this before.’

15.127 Lilith told Police that her and Jo had had an argument, as Jo had been drinking. Lilith said that Jo had a problem with drink, she had "stormed" out, had superficial cuts to arms, had been gone over 24 hrs, and not returned. Lilith said that this had happened before, but Jo had returned sooner that time. A Missing Person report was created by Police.

15.128 **22nd June 2021** The crisis team report at **07.23 hours** that Cumbria Police had shared information with them that Jo was missing, therefore proportionate information was shared with Police relating to Jo from their records.

15.129 Jo returned to the home she shared with Lilith of her own accord on the 22nd June, she told police officers who attended to see her that the support services were not concerned by her alcohol issues. She said that she had been sat behind a fence next to the house for 2 days, adding that she had gone missing as she was feeling low about drinking and had had an argument with her partner, Lilith, and was using alcohol to mask her feelings.

15.130 When Police spoke with Lilith she stated that she had had enough of Jo’s drinking which she claimed was constantly getting worse. Lilith said that Jo was drinking all the time and ordering alcohol via the ‘Just Eat’ app at 8am.

15.131 Lilith said that Jo’s mental health was ‘terrible’, and this was making Lilith herself ‘worse and worse’. She said that she felt she that she had to constantly keep watch and try to keep Jo safe. Lilith said that when she goes to work she fears Jo will just drink and become even worse. Prior to going missing Jo had self-harmed with a razor.

15.132 Jo had text her mum saying "I DONT WANT TO LIVE. DAD MADE IT CLEAR HOW MUCH I'M WORTH. I'VE SPENT MY LIFE MAKING SURE EVERYONE ELSE IS OKAY AT THE ECPENSE [sic] OF MY MENTAL HEALTH. I SHOULDNT FUCKING BE HERE."

15.133 A DASH risk assessment was completed by Police with Jo and initially graded as High risk, but on review by the Safeguarding Hub, this was regraded to Medium risk.

15.134 The reviewing Detective Sergeant (DS) in the Safeguarding Hub did not agree with the High risk grading of the situation and regraded it to Medium risk based on the fact it was a 'verbal argument only' and there was 'no disclosure of any offences or abuse' by either Jo or Lilith. The DS stated they felt it clear that Jo was drinking and had mental health issues that were causing the strain in the relationship.

15.135 As Jo had been found safe and well and has disclosed her alcohol and mental health issues to police, and her and Lilith both seemed willing to accept support and advice, it could not be assessed as High Risk[15]. The SPA line had been contacted at the time as a further safeguarding measure for Jo, hence further adding to the decision to re-grade to a Medium risk situation; as such it was not referred to MARAC as only cases deemed High Risk are eligible for a MARAC discussion.

15.136 During the course of the missing person investigation, text messages were seen by police from Jo to her mother indicating she felt she had a poor relationship with her father.

15.137 The Crisis Team were informed that Jo had returned home, and that Lilith was seeking a Crisis Team assessment for her. Attempts were made to contact Jo at **16.50 hours**, but she did not respond.

15.138 Police were called by a member of the public who heard screaming coming from Jo and Lilith's address, the caller stated it had been on and off since Jo had returned but was worse now.

15.139 Police attended and spoke to both Jo and Lilith. Lilith agreed to stay at another address in the same street.

[15]Risk Assessment Categorisation: This is based on the Offender Assessment System (OASys) developed by the Prison and Probation Services definitions of what constitutes standard, medium, high risk.
Standard Current evidence does not indicate likelihood of causing serious harm.
Medium There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.
High There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.
Risk of serious harm (Home Office 2002 and OASys 2006):
'A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.
https://proceduresonline.com/trixcms/media/6627/dash-risk-assessment.pdf

15.140 Jo was seen by the Street Triage team (STT) and told them that she had been given a diagnosis of Emotionally Unstable Personality Disorder (EUPD) several years ago, but nothing further had been done in relation to this.

15.141 She told them that she took Fluoxetine as a mood stabiliser, but said she felt that it was not working and that it has side effects that could make her feel suicidal.

15.142 She said she had been missing for a number of days prior to this incident and had been sitting in a field nearby. Jo described her relationship with her partner Lilith as strained, saying her partner wanted to end the relationship, but Jo did not.

15.143 Jo stated that she has missed a phone call from crisis team earlier. She said that her emotions were extremely high at that moment, and she was struggling to manage them. Jo did state that she had no feelings or thoughts of self-harm or suicide.

15.144 Jo was referred to Lighthouse, Borderline and advised to attend her GP to discuss changing her medication as the current one had side effects that were making her feel suicidal at times. She already had the number for the crisis team and SPA line should she need them.

15.145 Jo stated that she struggled to ask for help, therefore the STT requested that Lighthouse ring her that night to negate this, especially as her girlfriend would be staying at a different address due to safeguarding. Jo was also given contact details for Relate, a couples counselling service.

15.146 Jo was assessed by the STT as being at low risk of intentional suicide and low risk of death through misadventure, although it was noted this risk would increase if Jo were to drink excessive alcohol and her relationship were to break down.

15.147 Jo was deemed to be safe in the address that night and had protective factors listed as the potential relationship revival, the fact she had puppies in the address and was watching the football.

15.148 Police completed a Safeguarding report in relation to the incident, and completed a DASH with Lilith, assessing the risk as Medium. During this assessment Lilith stated that Jo went through periods of 'being nice' to prevent a relationship breakdown and that she was fearful of ending the relationship as she was unsure how Jo would take it. Referrals were made to GP1 for Jo. GP1 records indicate this was not received until the 30th of June 2021.

15.149 **24th June 2021** Victim Support speak with Lilith following a referral from Cumbria police due to the incident on the 22.06.21, as Lilith was recorded as the victim. Lilith stated that she was not a victim of domestic abuse but that her partner, Jo, had mental health issues and needed help. Lilith said that the mental health team wouldn't help Jo as she was drinking so much alcohol, and Lilith felt like they were just going round in circles. Lilith declined any further contact from Victim Support.

15.150 **28th June 2021** Jo calls GP1, asking to switch her medication from one antidepressant to another as it wasn't suiting her. This demonstrates she acted on

the advice given to her by the STT on the 22.06.21. They discuss changing from Fluoxetine to Citalopram.

15.151 **29th June 2021** GP2 receive a further letter from Unity asking for a prescription, if Jo's weight was 60kg and the blood test for her kidney function was satisfactory.

15.152 **30th June 2021** A letter was sent to Jo by GP1 after she had spoken with the crisis team following police attending due to a 'row with her partner', the incident that occurred on 22.06.21.

15.153 **2nd July 2021** GP2 text Jo regarding her prescription. The text was sent on a Friday evening close to Midnight, as the GP had likely been working all day but had still managed to get prescription sent to pharmacy for thiamine[16].

15.154 **5th July 2021** Jo makes another self-referral to First Steps (IAPT) for support.

15.155 Text sent to Jo by GP2 asking her to contact them regarding a non-urgent message.

15.156 **6th July 2021** IAPT review Jo's self-referral and past history of contact, plan to discuss referral with Community Treatment Team. Following this discussion, a Unity referral was recommended.

15.157 GP1 records for 6th July indicate that Jo had a face to face meeting with the crisis team *'following a row with her partner, a neighbour had called the police after hearing them argue.'* (This seems to refer to the incident on 22.06.21).

15.158 The crisis clinician records that First Step contacted the Single Point of Access (SPA line) to refer Jo to the Community Treatment Team, on review, Unity referral was indicated to reduce alcohol consumption in the first instance, prior to Community Team referral being considered.

15.159 Jo attended Unity for planned assessment which was undertaken face to face; no concerns regarding Jo's presentation were observed or recorded.

15.160 Jo disclosed drinking alcohol every day for the last two weeks, 2 bottles of wine per day.

15.161 Jo described experiencing withdrawal symptoms in the morning including shaking, sweating and increased anxiety. Jo identified lockdown as a trigger and also having relationship difficulties with her current partner (Lilith).

15.162 Jo expressed a desire to address her alcohol use with prescribed Acamprosate and a detox. Jo's Alcohol audit score was 20+ (a score of 20 or more indicates possible dependence) and Severity of Alcohol Dependence Questionnaire (SADQ) was 34 (a score of 21 or more indicates high dependence.)[17]

[16] https://cks.nice.org.uk/topics/alcohol-problem-drinking/prescribing-information/thiamine/
[17] https://cks.nice.org.uk/topics/alcohol-problem-drinking/diagnosis/how-to-screen/

15.163 Jo stated she was currently having difficulties with her partner and had a poor relationship with her Dad. She informed the Unity assessor that she had a strong support network from her Mum and brother.

15.164 Jo expressed a desire to become abstinent from alcohol because of the negative affect it had on her emotions. The Unity notes state that Jo had previously worked with mental health services. Jo reported no physical health concerns at this assessment, and she was already prescribed Thiamine to support with the physical health implications of her alcohol use. Jo disclosed that she had struggled with her mental health for years.

15.165 Jo discussed Borderline Personality Diagnosis (BPD) with the assessor, but it was not clear if this was a formal diagnosis. At the time of the assessment Jo was prescribed Fluoxetine for depression/anxiety. She disclosed a history of self-harm and previous plans to commit suicide.

15.166 Jo also shared that she was involved in the criminal justice system due to being arrested for drink driving on 30.05.2021 and had a court date of 26.07.21.

15.167 Jo explained that she was driving without a licence and had a previous charge for drink driving. Jo said she currently lived with her girlfriend Lilith, who owned their home. Jo declined the involvement of her family or partner in her care at the time of assessment.

15.168 At time of assessment Jo advised the assessor that she was able to guarantee her safety and had the numbers for the crisis team if required. There were no immediate safety concerns identified during the assessment appointment.

15.169 A plan was agreed that Jo would be allocated to the care of a Recovery Coordinator within the Unity Team, a GP summary was to be requested, GP bloods request letter provided, and a recovery plan appointment provided.

15.170 **7th July 2021** Unity worker called Jo to check in with her but got no response.

15.171 **8th July 2021** Jo had a follow-up call with GP1 and is recorded on their notes as 'doing well'.

15.172 **12th July 2021** GP2 send Jo a standard 'missed appointment' text message.

15.173 **17th July 2021** Police received a call from Lilith's mother reporting that Lilith had called her, crying and saying that Jo had been kicking off and there was mention of a smashed glass. Police attended Lilith and Jo's address and initially got no reply.

15.174 Enquiries with a neighbour indicated that there had been a commotion there the night before. A short while later the door was opened to police and Jo and Lilith were both inside.

15.175 Just 8 mins after door was opened, the officer at the scene provided an update that there had been a 'verbal only altercation' between Jo and her partner, that Jo had

thrown a phone at a glass which had subsequently smashed. The officer recorded that 'no one was alarmed or distressed', and that one person was leaving to go and stay elsewhere and that no offences had taken place.

15.176 The officer completed a Safeguarding form in which they stated the house was tidy with several empty wine bottles out on the kitchen counter and in the living room. They also noted that there was smashed glass in the living room and blood from where Lilith had stood in it and been cut. Lilith had glass in her foot and Jo had a cut to her hand from the glass.

15.177 Lilith stated that they had got into a verbal altercation about Jo being intoxicated. Jo had thrown her phone at a wine glass in the living room causing it to smash but no assault had taken place. Lilith had then phoned her mum about the incident as she was upset. The officer records that Jo provided an account with a similar version of events.

15.178 The officer assessed the matter as Medium risk non-crime domestic, recording Jo as the suspect and Lilith as the victim.

15.179 **20th July 2021** Jo contacted the Crisis Team at 10.26am requesting copies of her previous assessments with the team to share with mental health services, these were provided.

15.180 Police receive a call from a neighbour reporting that there was a domestic between the two females who lived at Lilith and Jo's address. They were reportedly in the front garden shouting at each other and then one walked off whilst the other went back inside.

15.181 The caller has then seen the female that walked away sneak into the rear of the property, and she was concerned that there was something going on inside. Police attended and spoke to both Lilith and Jo separately, who both stated that a verbal argument had occurred.

15.182 The officer completed a Safeguarding form which documented the following; "*Jo is due to go to court on Monday for previous offences and is potentially going to prison so is panicking and both parties are stressed because of this.*" It is not clear who the source of this information was from Police records.

15.183 Jo was again recorded as the suspect and Lilith as the victim. The Safeguarding form was shared with the IDVA service after being graded as Medium risk.

15.184 **22nd July 2021** GP2 tries to call Jo but does not manage to reach her after two attempts during the day.

15.185 **23rd July 2021** Jo had a face to face appointment with Unity worker. Jo said she'd had no alcohol for a few days, but over previous few weeks had had a few binges. Jo would usually drink wine and beer which she said lowered her inhibitions and increased her anger. Jo stated this caused conflict with partner and admitted that she hits '*self-destruct*'.

15.186 Jo described her main cause of stress as being the upcoming court date relating to her driving offences, she was very anxious about this. Jo said that things at home were improving and described Lilith as supportive, but said Lilith was finding 'the strain of Jo' difficult. Jo remained signed off from work and was struggling to fill her time. She said she had family nearby, but that the relationship was strained.

15.187 Jo described health and good and was taking Acamprosate and Thiamine and said her mood had been 'up and down', but she was taking Fluoxetine and due to switch to Citalopram due to the side effects. Jo said that she could be *'impulsive and erratic'* but had no thoughts of suicide/self-harm at present but admitted that this tended to *'come in waves'*. Jo expressed an awareness of who to contact and what to do when she had concerns regarding her mood and explained that she was in regular contact with the Crisis Team, was open to Liaison and Diversion and due to receive support from First Steps.

15.188 Jo expressed a goal to work towards abstinence but also explained she still wanted to drink as she enjoyed it. Jo accepted that her mental health was the underlying issue to her drinking and felt that once this was under better control she could look at abstinence, but until then she felt the need to access support to manage risk and reduce alcohol use.

15.189 Jo agreed a plan when drinking she would avoid white wine, and if buying wine, she would buy a type with a lower percentage of alcohol. She would aim to drink beer, avoid drinking out of the house and avoid drinking two days in a row.

15.190 **26th July 2021** Jo attended court and was sentenced to a 24 month Suspended Sentence Order with Rehabilitation Activity Requirement (RAR), Alcohol Treatment Requirement and Unpaid Work. The index offence was for Drink Driving on 30th May 2021 (*paragraph 15.94*).

15.191 Probation report that Jo was offered an initial appointment via telephone and that there was a change of probation practitioner. They state that whilst Jo was inducted within policy timescales and framework, the initial sentence plan was not completed within 15 days and an assessment was not completed until 26.11.2021, 4 months after the sentence.

15.192 Jo attended A&E with an injury to her right knee, no further details provided to the panel in relation to this.

15.193 GP2 record a note coded as Alcohol dependence (likely after reviewing the Unity letter from 29.06.21) and a text message is sent to Jo requesting she arranges an appointment to attend for bloods to be taken and her weight to be checked.

15.194 **27th July 2021** GP2 text sent to Jo confirming appointment for 04.08.21 at 10:45 hours.

15.195 **28th July 2021** Jo's mum's dog died, leaving Jo very upset.

15.196 **29th July 2021** GP1 calls Jo for a follow-up check and she explains that she had not started the new anti-depressant medication as First Step felt that her working with the Community Mental Health Team (CMHT) was more appropriate.

15.197 **30th July 2021** A member of public called police to report domestic issues constantly occurring at Lilith and Jo's address, stating that they argue and shout on the street, saying they were shouting that morning on the street and one of them was absolutely sobbing afterwards. The reporting person is very concerned as the issues are constant.

15.198 Police attended and spoke to Lilith who explained that Jo was at court earlier that week for drink driving, driving without insurance and driving whilst disqualified and that this had caused a number of arguments between the pair. She also said that Jo was an alcoholic which caused them to argue, however she now has a court order to attend Unity which Lilith believed would help.

15.199 Lilith confirmed there had been no assault or other offences that had taken place, just a verbal argument. Lilith reported that whenever they argued, and Jo was under the influence, that she would go outside into the street and shout which is likely why someone had called police.

15.200 Lilith told officers that her and Jo were no longer together, but that Jo was staying at the property whilst she looked for somewhere else to live.

15.201 Jo was not in the property at the time so was not spoken to. Police tried to make contact via phone but were unsuccessful.

15.202 The worker from Unity called Jo and did manage to speak to her. Jo explained that she was in A&E with a head injury after tripping over the door mat. Jo described the possibility of requiring treatment in the form of gluing or stitches to her injury. Jo said that the outcome at court had been a driving disqualification for 40 months. Jo said she was drinking up to 3 days per week, felt in control of this and was taking her Acamprosate. Jo agreed to attend the brief intervention group on 12.08.2021.

15.203 **31st July 2021**

15.204 A 101 call to police was made by Jo, who stated she was in A&E in Carlisle and had been assaulted by ex-partner the previous afternoon (30th July). Police attended CIC and Jo's home address, but she was not there. She was left several voicemails.

15.205 Jo then later contacted 101 at around 4.20pm stating that she did not wish to make any complaints, she had sorted things out with her partner, and was currently out in the lakes with her partner and didn't know what time they'd be home. She was advised that due to it being a domestic related call, police still needed to come and see her.

15.206 Due to there being no available 'diary appointment', Jo was advised to attend the police station to speak with an officer. A West Cumbria police officer spoke to Jo in Whitehaven police station.

15.207 Jo informed the officer that she and Lilith had been 'bickering' but would not describe it as an argument. She said she had then tripped over a Jack Russell puppy and hit her head on a TV cabinet, hence why she was in CIC with head injuries.

15.208 Jo explained that she had 4 stiches in the right hand side of her forehead and a black right eye. Jo was asked several times whether she was assaulted or if Lilith had caused the injuries, but she denied this was the case.

15.209 She stated that if she had been assaulted then she would tell the police as she would have no reason not to, but this just wasn't the case. She was signposted to victim support, and the officer noted that Jo was already known to the crisis team and 'The Lighthouse'[18].

15.210 Jo stated that she and Lilith had sorted things out and they had gone away for the day to clear their heads. She stated that she was safe and was not in danger. She did not give the officer the impression that she was in fear or that she was scared. She was told to keep her mobile phone charged and accessible and to utilise 999 if required.

15.211 Jo denied telling staff at the hospital that she had been assaulted, saying she believed there had been a miscommunication somewhere and that they had 'contacted police to be on the safe side'.

15.212 No DASH risk assessment was completed with Jo and no crime report was created as there was no confirmation of an offence and Jo was adamant that the sufficient support services were in place to address her safeguarding needs.

15.213 The officer did not challenge Jo with the fact that she was the one who had called and reported the assault, not the hospital staff.

15.214 **4th August 2021** Jo attended GP2 appointment for blood tests. Her results were returned same day, and the GP sent a text to Jo at 11.05pm that evening to say her bloods were fine and requesting an up-to-date weight as this was not checked as planned when in the surgery.

15.215 **6th August 2021** GP2 record Jo's weight and the correct Acamprosate dose is calculated. Medication for Jo was prescribed, and the prescription sent with text to Jo at around 7.30pm from the GP, informing her that the prescription had been sent.

15.216 **9th August 2021** Jo attended A&E with a laceration to her head she stated she got after a fall. She reported she had lost consciousness and felt unwell.

15.217 **13th August 2021** Jo attended GP2 for the removal of 4 sutures from the skin above her right eyebrow. There were no notes made by GP regarding the cause of this injury. The notes received at the surgery in relation to the injury documented that Jo had been 'pushed over' two days earlier by one person, unnamed.

[18] The Lighthouse, operated by Carlisle Eden Mind, serves as a haven for those navigating a mental health crisis in Carlisle and Eden. https://cemind.org/our-services/the-lighthouse/

15.218 **17th August 2021** Jo had a telephone call with her PSO at the start of her second community order. The PSO described Jo as showing insight into her triggers and motivation. Jo explained that the drink driving offence which led her to probation had been as a result of 'her partner reporting her missing twice to the Police'.

15.219 Jo openly discussed her mental health, saying she had recently been prescribed fluoxetine by her GP but felt this had increased her suicidal thoughts. Jo went on to disclose that she had one day walked on a railway line but had changed her mind as realised how selfish this would be. Jo was able to recognises that her alcohol use had become a maladaptive coping strategy. Jo identified that her mental health really started to decline 2018 and this was when her alcohol use increased**.**

15.220 **28th August 2021** Jo loses possession of her iPad and mobile telephone. It remains unclear how this happened as several different accounts were provided by Jo as to where they went. Three different accounts Jo provided include robbery, theft whilst asleep and loss due to her own intoxication and carelessness.

15.221 **29th August 2021** Victim Support records indicate that Jo reported to Police that she was walking down the road the day before (28.08.21) when she was pushed by an unknown suspect and had her iPad and mobile phone taken.

15.222 Police records, however, indicate that this occurred whilst Jo was asleep in Penrith after having consumed alcohol; Jo's handbag had been left unattended next to her and an unknown person had stolen the handbag and contents which included her iPad and mobile telephone.

15.223 Jo had reported to her PSO that on **Saturday 28th August** she had gone to Appleby for the day to visit her mum and had taken a bag of belongings with her, including her iPad. She said that Lilith had later picked her up and they drove to Penrith where they had agreed to meet some of Jo's friends for drinks who she'd not seen for a long time.

15.224 Lilith had a different version of events, as she messaged Jo's mother telling her that Jo had been fighting in the car with her and so Lilith had left her in Penrith, where she had proceeded to go round all the pubs and get drunk. Lilith told Jo's mum that Jo had been beaten up and had her iPad and phone stolen. Jo's mother remembers speaking to Jo a few days after this incident and Jo was using her iPad, which her mother found really strange.

15.225 Jo then disclosed that "*things got a little out of hand*". When she was asked to explain this further, she reported having between 4 to 6 pints of beer, and said she'd not eaten all day. Jo stated she was "*not the most drunk she'd ever been*". The PP felt Jo was minimising her alcohol use and justifying the level of intoxication she had reached.

15.226 Jo then reported that she and Lilith had both left their house keys behind, so a friend had driven Lilith to Kendal to pick them up. Jo then went to get a taxi home and realised that her bag was missing, admitting she had been a bit careless with it, and saying it had contained her "*whole life*" (car keys, iPad and phone).

15.227 It is unclear from information seen by the panel which if these differing accounts was accurate.

15.228 Jo's iPad has never been found or recovered throughout the police investigations and remains missing. Her mobile phone was handed in to a Police station in Penrith, over two months after it had gone missing, by a café owner who had held onto it in the hope the owner might return for it.

15.229 **30th August 2021** At around 1.40am a member of the public called police to report that Jo had been headbutted by her girlfriend Lilith, who was then driven off in a vehicle. Jo was described as having a cut to her forehead and her legs and was being looked after by neighbours until Police arrived.

15.230 Police attended and found Jo at the location. At the same time, Lilith turned up at the nearby Police Sation and reported that Jo had bitten her face. Officers noted that Lilith was highly intoxicated.

15.231 Body worn video (BWV) footage from the police who attended Jo's location shows the officers and paramedics asking her what happened; two officers and two paramedics ask her questions in quick succession. She tries to tell them "*I have been abused*" and talks about an injury to her head happening that night and mentions something happening few weeks earlier. She appears to become confused and so do those who are asking her about the sequence of events.

15.232 Police make the decision to arrest Jo on suspicion of assault on Lilith. The officer states that the reason that Jo was arrested was not only due to the disclosure made by Lilith about Jo biting her cheek, but also due to Jo's high level of intoxication and the danger this was causing to her, as she was reportedly 'wandering in the road and into neighbours' houses'.

15.233 When being booked into custody following her arrest, Jo was placed on 30 minute rousing observations as the staff felt she was an alcoholic and were concerned she may suffer from withdrawal symptoms. Jo denied having a problem with alcohol.

15.234 Jo was seen in medial room in custody several hours later by a health care practitioner in relation to reports of alcohol dependence, anxiety and depression. Jo was described by the health care practitioner as being alert and orientated, well kempt, and well engaged throughout the assessment. No signs of significant alcohol withdrawal were seen at the time of the assessment and Jo did not appear intoxicated. Jo had stated she had no current or recent thoughts of deliberate self-harm or suicidal ideation and worked full time as a marketing and sales assistant. She said she was receiving helpful support from Unity and now only drinks alcohol at weekends and not daily. Jo accepted a referral to the Liaison and Diversion team (L&D.)

15.235 Jo was assessed in custody by L&D; Jo indicated that she had been attacked, and her bag had been stolen in Penrith two days ago. She said she did not recall too much due to her alcohol intake however states her phone was taken and this has caused issues with communication.

15.236 Jo reported that she was still drinking on a weekend however she can abstain during the week, she is attending Unity group sessions and due to engage in one to one sessions soon. She reported that her mental health was stable and said she was taking 20mg of citalopram daily to help manage this.

15.237 Jo denied any suicidal ideations and there were no reports or evidence of perceptual disturbances. Jo didn't identify any gaps in her current support.

15.238 Jo was released with no further action from custody at around **12.00pm** after giving a 'no comment' interview. There was not enough evidence to proceed to charge as Lilith had not provided a statement in support of police action against Jo. The case was reviewed at the time by a domestic abuse Evidence review officer ERO[19].

15.239 Unfortunately, there is no mention made by the ERO of the original caller who reported witnessing Jo being headbutted by Lilith, who was then driven away. The ERO identified no line of enquiry to revisit them.

15.240 The ERO review mentions a witness saw Jo pull Lilith's hair but did not see her bite Lilith, however that information was not reflected on the investigation plan.

15.241 BWV shows the officers taking details from witnesses but doesn't show if they were asked if they would provide a statement relating to what they saw. BWV also shows the witnesses took Jo in, the police and the paramedics going in and out of the house discussing what Jo and Lilith had said; this was all in front of the witnesses and a male witness can be seen to include the information he possibly didn't know into rationalising what he saw. This is poor practice and likely had a negative impact on the ability to obtain accurate and independent accounts of what had occurred.

15.242 At around **8.15pm** Police receive a call from member of public stating she has come across Jo on the street in Carlisle and Jo was claiming to have been pushed from behind by an unknown male causing her to fall face forward and causing injury to her hand, knee and foot. Officers attended and spoke to the caller at the scene who stated she was walking down the road when she saw Jo looking upset and distressed. Caller had asked Jo what was wrong when Jo had told her she has been attacked in the lane behind a nearby convenience store.

15.243 Jo was spoken to by officers and stated she had just got back from Appleby and was walking from the train station to the hospital as she had hurt her foot the previous day in an accident, when she was attacked. She said she'd been walking when she has been pushed from behind causing her to fall to the ground, causing injury to her hand, knee and foot. The male had then grabbed her left arm before running off swearing.

[19] "To improve the quality of investigations the constabulary is increasing the number of evidence review officers. **These are specially trained staff who are accredited to help them scrutinise investigations to achieve the best outcomes for victims.** The constabulary is providing training so that all sergeants can become accredited evidence review officers." https://hmicfrs.justiceinspectorates.gov.uk/peel-reports/cumbria-2023-25/

15.244 Jo complained of pain in her left foot and hand but had no visible injury and neither appeared broken as she was able to move her hand and walk on her feet with no difficulty. Whilst police were in attendance Jo's account of what had happened changed several times and she appeared intoxicated and/or suffering from mental health issues.

15.245 Officers spoke Jo's partner Lilith who informed them that Jo had just been released from police custody after being arrested for assaulting Lilith the night before.

15.246 Police identified another crime report recorded on the 29th August where Jo reported she had been a victim of a robbery. Officer's state that Jo was not making much sense. When officers had called Lilith, she had told them that Jo was "*a serial liar with a drinking problem*".

15.247 A crime of assault was recorded by officers in relation to Jo's allegations, and she was taken to hospital so that her medical needs could be attended to. They planned to contact her at a later stage to ascertain full details of the assault. Jo was then taken to A&E by Police and left in their care.

15.248 This assault crime however was subsequently filed as 'No Further Action'. The investigation log records that Jo had made a "*dubious report of assault*" and was highly intoxicated at the time and that her "*version of events kept changing*". As there were no known suspects, no witnesses and no CCTV the matter would be filed with no further action.

15.249 A SAF VA form was completed and submitted for Jo and was reviewed by the safeguarding hub who assessed that there was no requirement to share the information as Jo "*had access to health professionals whilst in custody and she has attended hospital.*"

15.250 Later that night Jo had turned up at female's property stating she had been kicked out of her address by Lilith, and she had nowhere else to stay. The female had reluctantly allowed Jo into the property and allowed her to stay the night as she felt sorry for her.

15.251 **31st August 2021** The female that Jo stayed with drove her to Durranhill Police Station in Carlisle, advising her to report her account of events with Lilith to the Police. The female left Jo there.

15.252 This female has then been in contact with Lilith who reportedly informed her that Jo had a 'GBH charge against her' and was only allowed back at their address under police escort. Lilith had told her lots of other information which had persuaded the female not to get involved with Jo, this included that Jo was an alcoholic and stole things.

15.253 At around 7.30pm a member of the public found Jo under a bridge on a street in Carlisle and called Police with concerns for her welfare. The caller relays messages from Jo that she has had a domestic argument with Lilith, who has refused to let her in the house following her arrest and she has been sleeping rough since.

15.254 The caller reported that Jo lives with her partner and was saying she was fearful to return home. Jo's account was muddled, and she was not making much sense, but she stated she was in Penrith with her partner Lilith when she had her drink spiked and was assaulted, resulting in a broken toe and finger. Jo stated this had already been reported to police as she returned to Carlisle on Saturday 28th.

15.255 The caller took Jo to the hospital (CIC) as she had bruises all over her and left her in their care, but there was no record of Jo booking into A&E or being seen by medical staff.

15.256 At around 10.20pm Police could not locate Jo and A&E and were unable to get hold of the original caller who found Jo and took her to hospital. They therefore contacted Lilith who stated that had not seen Jo since her arrest on the early hours of that day and following her release from custody Jo had not returned to the address. Lilith said this was due to the couple not getting on recently. Lilith stated she had spoken to Jo and believed she was staying with a female associate. Lilith did not report Jo as missing.

15.257 Police created a Missing Person Report for Jo, graded as Medium Risk, and this was reviewed by the Safeguarding Hub who suggested that a SAF should be submitted for Jo when she was located so that other agencies could support as required. Sadly, this does not appear to have been reviewed or actioned after she was found.

15.258 **1st September 2021** Jo has again turned up at the female's home she stayed at on the night of the 30th August and sat on the doorstep asking to be let in. Jo was said to be making distressed wailing noises. The female did not allow Jo in and was concerned about what Jo may do. The female contacted police on 101 however no officer was deployed to the address. Jo eventually left the female's address at around 4.00am and was not seen again by her after that.

15.259 No police unit was sent to check the area and no SAF was submitted in relation to Jo being a potentially vulnerable adult. Had a systems search been carried out the call handler would have identified that Jo was missing and could have sent an officer to the address to locate her and check her welfare.

15.260 This would have enabled Jo to have been spoken to alone and away from the home address to ascertain any issues, away from Lilith, so this was a potential missed opportunity.

15.261 **2nd September 2021** Jo returned to Lilith's address at around 1.00pm and was visited there by police. Jo said she had been rough sleeping. The missing report states that she was asked about any support required and this was refused stating that she was okay at the minute.

15.262 The officers note that there were issues with mental health and alcohol abuse and recommended 'relationship support'. It appears there was no additional safeguarding reports submitted as a result of this incident, with the rationale provided being that the safeguarding reports were submitted as a result of the

incident on 30th August *(paragraph 15.256)*, inferring that they felt the two incidents were linked.

15.263 **16th September 2021** The MARAC took place, and a case discussion held regarding Jo and Lilith, with Lilith as the victim and Jo as the suspect. An action was agreed for Jo to be informed about the 'Turning the Spotlight' program during her probation appointment that day.

15.264 Jo attended her appointment with Probation and was extremely apologetic, for many different things including not being contactable, she apologised to her previous probation officer for being back on probation, she apologised for getting upset and she apologised for missing her unpaid work. Jo presented as lacking in confidence and self-esteem.

15.265 Jo and her probation officer discussed the offence and the recent incidents involving her partner Lilith. Again, Jo was quite avoidant to discuss detail and minimised what detail she did share, however this appeared to be as she felt shame about her behaviour, as well as possibly not yet feeling comfortable to discuss with the probation officer due to it being early into the Order and rapport was still being built. The probation officer informed Jo that she had received information from Police and so was aware of the details of the most recent incident.

15.266 They discussed Jo and Lilith's relationship, and Jo expressed that she felt that the relationship was very one sided in terms of house work and responsibility. Jo described Lilith having been there for her "110%" and more than her own family and stated that whilst she was unemployed she was happy to take more responsibility around the home, however now Jo working full time she found this unfair.

15.267 Jo also explained that the two moved in together very quickly describing them as being "*thrown together and living under each other's skin*", because of lockdown. The couple had decided to try and spend more time doing things apart, which Lilith sounds to have found easier as she has friends locally, whereas Jo was much more isolated, not being from Carlisle.

15.268 Discussing her mental health, Jo stated she felt that although when she started her Sertraline, she noticed an improvement very quickly, she now felt "*flat*" and doesn't think they are working as well. She said she was still on a dose of 20mg, so was encouraged to contact her GP to review her medication as they may look to increase the dosage.

15.269 She was also encouraged to ask her GP to make a referral to the Community Mental Health Team (CMHT), as this had not happened in the past despite having many dealings with the Crisis Team and also self-referring to First Step who felt that *'Jo's needs were too complex for them*'. Jo agreed to do this.

15.270 Jo stated she was doing more physical activity, which was a positive way to cope that Jo found helpful, however she disclosed she was still regularly experiencing suicidal thoughts, she said she had no intention to act on them.

15.271 The probation officer then introduced 'Turning the Spotlight'[20] to Jo and suggested that she could self-refer. No referral to the program was made by the Probation Officer at that point, it was left with Jo to progress.

15.272 **23rd September 2021** Jo spoke to her probation worker on the phone, she was in the car with Lilith, driving back from Manchester where they had been to watch a football match. During the call Jo said that all was going well, and she described the week as being "*a good week*". They discussed Unity and Jo said was scheduled to complete the group sessions on a Friday between 10-11am for the next 4 weeks, so has taken 4 Friday mornings as leave from work to be able to attend. They discussed and agreed to complete a Safety Plan in their next face to face appointment the following week.

15.273 **24th September 2021** GP2 had a telephone consultation with Jo regarding her medication. Jo was talking about changing from fluoxetine to citalopram but feeling the need to increase her dose. A seven day supply was issued by the practitioner who was working remotely. There was also mention by Jo of her seeing a GP in Temple Sowerby (GP1).

15.274 **28th September 2021** Jo called her probation officer asking for support with accessing counselling and finding her own accommodation. She described things as 'uncomfortable' at home, with her and Lilith not speaking and neither of them sure if they want to continue their relationship.

15.275 Jo described them as being "*under each other's skins*" and needing space. She denied any arguments or violence, however stated she had stayed at a B&B the previous night. They discussed an application for Cumbria Choice and private lets. Jo was unsure if her poor credit rating might prevent her being able to access a private rental property.

15.276 They discussed Jo's desire for support with CMHT and the probation officer encouraged her again to request her GP make a referral. A referral to 'First Step' had been made over the weekend, so Jo was advised to check the post as they were likely to send her a letter asking her to call for an assessment. Jo was also encouraged to contact the Lighthouse for support as this was an evening service so would fit in better for her employment as she said she struggled to make GP appointments during the day.

[20] **Turning the Spotlight** is a service offered by Victim Support Cumbria to support people who are having problems with their relationships, leading to arguments, an unhealthy relationship, and abuse. They work with both victims and perpetrators of abuse. Turning the Spotlight is a free, confidential, and non-judgemental service who work with couples and individuals, with or without children.

15.277 **1st October 2021** Jo had a phone appointment with her probation officer and said she was worried as she has been unable to join the meeting for Unity that day and no link was sent to her. She had tried phoning and emailing Unity but got no response. Jo was advised that it could be due to them being taken over by Humankind today and not to worry, as she has tried to contact them it would not reflect negatively on her. (Unity became 'Recovery Steps' from this point onwards).

15.278 Jo discussed her relationship said she was keen to find her own accommodation; however, she had not told Lilith this yet as she wanted to have something in place first. Jo said that Lilith "*hovers*" over her and always wanted to know who she was messaging, but did not in return tell Jo who she herself was texting, so it was a like different standards applied and it was not an equal relationship.

15.279 Jo explained that she had not felt able to ring the Lighthouse that week as it was on an evening when Lilith was around and so she could not have any privacy. Jo was asked whether she felt that Lilith was controlling in the relationship and Jo immediately answered '*yes*'.

15.280 They discussed whether this was healthy, and Jo agreed it was not. Jo said she also worried about Lilith cheating on her, as she has cheated on Jo in the past and in her previous relationships. When asked about this, Jo explained that Lilith kissed one of her friends and stated that her and Jo were "*on a break*" at the time and so it wasn't cheating. Jo felt that Lilith gave her the impression the next morning that they were together, describing Lilith as "*only wanting her when it suits*".

15.281 They went on to discuss 'Turning the Spotlight' and the support they could offer, and Jo said she was keen to engage with this. She disclosed that there was violence from both her and Lilith within the relationship, although she minimised this as "*just pushing and shoving*" and blamed alcohol for this.

15.282 When discussing safety planning, Jo admitted she does not want the police to become involved as she would '*like to think they're adult enough to resolve issues*', however confirmed that if things became physically aggressive, then she would call the police to keep them both safe.

15.283 Following an argument, the responsibility to leave always sat with Jo as the house was in Lilith's name, and Jo stated this meant she had to resort to sleeping on the street as she has no local friends or family. She said it was not a good situation to be in especially with her poor mental health.

15.284 Jo said she wanted the relationship with Lilith to work but felt that Lilith did not make the same effort as she did. Jo described how Lilith would become very defensive and noncommunicative and was not in touch with her feelings the way Jo was.

15.285 It was agreed that the probation officer would send Jo more information on Turning the Spotlight so she could self-refer, and that Jo would contact Cumbria Choice to

sort out access to her account with them. Jo was also to contact First Step as she had not yet heard from them and needed a CMHT referral. Jo said she had also been looking into joining a Hockey Team that met for practice on a Tuesday evening.

15.286 **7th October 2021** Jo was in the car with Lilith when her probation officer rang for their appointment. Jo said had been fine and the two were heard communication between each other which raised no concerns. Jo was still waiting for a GP to call her back regarding her medication. She was advised that she could contact Lighthouse on an evening, and they could potentially make a referral to CMHT for her. She was still considering starting hockey which would give her some space and provide an opportunity to meet new people. Jo could not go into discussion about housing, due to Lilith being present, so they agreed to have their next appointment in a month's time.

15.287 **20th October 2021** Face to face appointment with Jo and Unity/Recovery Steps worker; Jo disclosed she was drinking at weekends, with her partner, in a controlled way. She was drinking beer and avoiding spirits. Jo described her mood as 'up and down' and expressed needing to speak to her GP regarding an increase in her Citalopram medication. Jo expressed having no recent suicidal thoughts, but recent self-harm was disclosed. Jo explained that she still lived with her partner and expressed no concerns at that time. This was the last contact Unity/Recovery steps had with Jo.

15.288 **2nd November 2021** Jo spoke to GP2 complaining of blood in her urine and requesting a face to face appointment. This was arranged for the following day.

15.289 **3rd November 2021** Jo did not attend her appointment, so GP2 called her and conducted the review over the phone. Jo mentioned the termination of a pregnancy in early 2021 (nothing about this has been documented in her records) and a blighted ovum[21] five weeks earlier. Jo was advised to do a pregnancy test.

15.290 No further explorative questions appear to have been asked of Jo in relation to this. Given that Jo was in a same sex relationship and suffering from alcohol addiction, it is concerning that this was not discussed further.

15.291 The practice had previously received information from the Liaison and diversion team, back in June 2021, that Jo was in a same sex relationship and lived with her partner. The GP who spoke with Jo on 03.11.21 was unaware of this information but states that if she was, then she may have been more enquiring regarding the reported previous termination and the reported blighted ovum and home positive pregnancy test some 5 weeks later. On reflection, the GP felt that there was some detachment within the consultation, and she had to work hard to try and get engagement from Jo, but this was a recognisable issue when having a phone consultation rather than a planned face-to-face appointment.

[21] **Blighted ovum**; an anembryonic pregnancy whereby an early embryo never develops or stops developing, is reabsorbed and leaves an empty gestational sac.

15.292 The GP also noted that when having conversations over the phone, rather than in person, the risk of other parties being present with the caller is heightened and so entering into certain lines of questioning are not deemed safe or appropriate until the caller's immediate safety and privacy can be established. This is not always possible and so may have been a further reason why additional probing questioning was not initiated with Jo despite her disclosures of a prior termination and recent blighted ovum.

15.293 In all of the records seen by the panel, there is no other mention made by Jo about a termination or blighted ovum to any other professional, or to her family members, so we can only know that Jo said this was the case, without being able to confirm it was accurate, and if so, the nature of the pregnancies, any consent issues, planning or otherwise.

15.294 **5th November 2021** Call with Jo and her probation worker. Jo said she had been sacked from her job due to her criminal conviction. Jo said she had called Inspira[22] yesterday and was waiting for a call back today. Jo explained that Lilith had "flipped out" when Jo had told her about being fired and felt she was unsympathetic and not understanding. She said there had been arguments during which Lilith had called Jo "everything under the sun" and making sly digs such as "you won't be here much longer anyways" relating to Lilith saying that Jo needed to find somewhere else to live. Jo said that although the house was in Lilith's name, it was also Jo's home. Housing options were discussed, and Jo said she has spoken to CBL[23] and was waiting for an email from them. Agreed to have another appointment in 2 weeks' time.

15.295 **19th November 2021** Jo did not attend for her probation appointment, so the probation officer phoned her. Jo apologised for missing her appointment and said she'd been at the Job Centre most of the morning getting help looking for work. She has been referred to JETS[24] who had sent her CV for a couple of full time positions that would allow working from home.

15.296 When asked about her relationship Jo said that things had been 'going OK'; she said that Lilith was going to visit her mum in Kendal for the weekend straight after work today, so Jo was looking forward to having the house to herself and a bit of a break from Lilith. She said she had applied for Cumbria Choice for accommodation but had still not mentioned this to Lilith as she was 'worried as to how she might react.'

15.297 Jo said she had continued to remain abstinent from alcohol since her last appointment and said she was taking her mental health day to day, and that some days she had felt quite low, but had been able to manage this by getting out of the house for a walk with the dogs and ringing a friend of hers who lived in New Zealand. Jo mentioned that due to her lack of friends, she found it difficult to talk to anyone,

[22] **Inspira** is an employability and professional careers advice and guidance service.

[23] Eden Housing Association choice based lettings service called 'Cumbria Choice' (CBL).

[24] JETS – Job Entry Targeted Support a government program aimed at helping job seekers return to work.

describing Lilith as "a bit of a robot" and not being someone who talked about feelings and emotions. She described feeling much better that day as she felt she had been more productive.

15.298 Jo said she was keen to get out and meet people and make friends, however she felt anxious about "*how to make new friends as an adult*". Jo discussed her interests and where she might be able to find out about events, activities or groups that she could get involved in. Jo expressed a wish to get involved in something artistic and her probation officer suggested that Jo have a look to see if there is anything on at a local museum/community hub.

15.299 Jo also discussed her unpaid work requirement (UPW) and the need to re-start this at weekends as she was feeling a little more settled and able.

15.300 **29th November 2021** Jo called GP2 speaks to GP complaining of suicidal thoughts and wanting to increase her medication. She discussed having Crisis team intervention "a few months ago". A Citalopram prescription was issued. This was the last contact she had with GP2.

15.301 **3rd December 2021** Jo contacted probation to apologise for missing her appointment and explaining that she was in mental health crisis, which resulted in her feeling suicidal on the previous evening and being out on the street all night. She said she did go to A&E at one point due to the cold weather and struggling. The probation worker checked whether Jo felt able to attend her appointment in a weeks' time so they could discuss what had been happening for her, Jo agreed to this. confirmed.

15.302 **8th December 2021** Jo again self-referred to First Step requesting support due to experiencing 'severe depression and feeling suicidal'.

15.303 **10th December 2021** Jo does not respond to telephone contact from IAPT practitioner to complete a risk assessment. A message was left requesting Jo call back them. On receiving no response, an email was sent requesting she contact them, which included crisis and contingency planning advice. Jo did later contact the team, reporting she was at work and denying any suicidal ideation. It was agreed that Jo's referral would be triaged for future treatment options. This was two days before Jo went missing prior to her death.

15.304 **10th December 2021** Jo attended her probation appointment and presented as tearful and drooping in her body language (contracted chest, bowed shoulders, head down and arms crossed). She explained that on the evening of the **2nd of December** she had argued with Lilith and run away.

15.305 Jo said that both her and Lilith had self-harmed, and Jo showed 20-30 superficial scratches to her left arm that she had inflicted on herself. Jo was supported to explore her motivations for her behaviour, and she expressed that Lilith did not provide emotional comfort for Jo when she was distressed, Jo said she had thought *"I just want someone to love me".*

15.306 The probation officer spoke to Jo about her relationship with Lilith and Jo admitted that Lilith had been physically violent towards her, and that she felt that she had also been subjected to emotional and psychological abuse. They discussed options available to Jo for support and she was signposted to Victim Support, agreeing to do some more work on the topic the following week.

15.307 Reflecting on her relationship, Jo said that she did not want to 'continue trying' as she did not feel that Lilith reciprocated her effort. She admitted that she was still there because she had nowhere else to go, and was fearful that Lilith would eject her from their home.

15.308 Jo accepted that there was no trust in the relationship and that she had withdrawn from friends because Lilith would behave in an accusatory way when Jo texted other people. Jo said that despite this, Lilith was very secretive with her own phone.

15.309 Jo's accommodation options were discussed and said she missed her family and so wasn't sure she wanted to stay in Carlisle. She said she had been thinking about Manchester or Liverpool, as her new job (remote working Customer Support for an insurance company) had offices in those two cities.

15.310 Jo was provided with contact numbers for if she is in Crisis and was advised to seek a further review with her GP and request a CMHT referral. Her medication had been increased from 20mg daily to 40mg, but Jo said she felt like she was getting worse, not better. Probation officer said they would look at making a referral to CMHT as well. It was agreed that weekly contact over Christmas would remain to monitor Jo's current situation.

15.311 **12th December 2021** Jo is last seen alive by Lilith, who reported that Jo had said she was going out to 'clear her head'. Later that evening Jo sends a text message to Lilith which stated she was waist deep in water. Lilith does not report this to the Police.

15.312 **14th December 2021** Two days after Jo is last seen Lilith contacts the police and reports Jo as missing. She says that Jo left their address at 3.30pm on 12th December stating that she wanted to clear her head. She also informs them that Jo had later sent a message to Lilith stating that she was 'waist deep in water'. Lilith stated that she delayed reporting her as missing as Jo had 'previously done similar and returned home safely' on those occasions. A high risk missing person investigation was commenced by Cumbria Constabulary.

15.313 **24th December 2021** Jo's mobile phone was handed into the Police Station at Penrith. A local café owner had found it and held on to it for a couple of months in case someone came back to claim it, when no one did they handed it to the police. The phone was stored in the 'found property' box for several weeks until it was charged up and a picture of Jo was seen on the screen by an officer who recognised her as a current missing person and subsequently gave the phone to the investigating officer.

15.314 **21st February 2022** An extensive police investigation was undertaken and sadly, Jo was found deceased on in marsh land at around 3.00pm by a member of the public.

15.315 Since that time, Cumbria Constabulary have undertaken investigations into the offence of Controlling and Coercive behaviour whereby Lilith is suspected of being abusive to Jo. On 26th April 2023, the decision was taken to finalise this investigation with no further action to be taken due to undermining material, such as reports suggesting that, at times Jo was the aggressor in the relationship and that witnesses close to Jo did not believe that the behaviour from Lilith amounted to being criminally controlling and coercive.

15.316 A subsequent review of this investigation was then conducted in December 2023 following information that the mobile phone belonging to Jo had been accessed by the Police's Digital Forensics Unit.

15.317 The decision to file the criminal investigation as 'no further action' was made again on **29th February 2024.**

16 OVERVIEW

16.1 **This section of the report provides an overview that summarises what information was known to the agencies, professionals and others involved in Jo's life about her and about her relationship with Lilith.**

16.2 **Summary of information from family, friends and other informal networks**

16.3 Jo had several half siblings and lived with her parents until they separated in 2008 when Jo was 15 years of age. Jo's father describes her a being a 'dream child', a really good kid who never argued and did not seem to have any troubles until she entered her teenage years. He felt as though Jo then struggled with her own identity and describes it almost as if Jo was 'holding back' about what she would share in terms of her emotions and inner world.

16.4 Jo went to university and held some good jobs after leaving which she was successful at including as a buyer for a steel suppliers in Carlisle.

16.5 Jo's mother describes having a great relationship with Jo and them speaking about their lives to each other daily.

16.6 Jo's mother describes Jo's relationship with Lilith as happening quite quickly. It was after about 3 months of Jo being with Lilith that she started to see 'warning signs', describing Lilith as controlling and isolating Jo from her family and friends. She explained that Lilith would check Jo's mobile phone to the extent that Jo would ask her family to be very conscious of what put in messages etc, as Lilith would see it.

16.7 She describes that they would often hear shouting when they were on the phone to Jo, and she had often turned up to see them with black eyes. Lilith would tell them

that Jo's injuries were related to her excessive alcohol consumption, but the family now question this and wonder whether Jo was being harmed by Lilith.

16.8 Jo had told her mother that Lilith was taking all of her money to pay the bills and so she was left unable to pay off her credit cards. Lilith's previous girlfriend was living at the address with her and Jo for around six months and this caused a volatile environment.

16.9 When Lilith's ex-partner eventually moved out, Jo's mother says things between Jo and Lilith seemed to improve. Jo secured a full time job, and the couple had dogs which Jo would walk in the mornings before showering and heading off to work. Jo would return home at lunchtime to make lunch for Lilith, but Jo's mother said Lilith never seemed happy with what Jo did for her.

16.10 Jo told her mother that Lilith had stopped her coming to visit her family, and whenever she was invited over by her mum, Lilith would arrange alternative plans or tell her she needed to stay home to look after the dogs.

16.11 Jo's family made numerous attempts to support her to leave the address she shared with Lilith and get her separate accommodation, but sadly this never happened. About a year before Jo's death, she had told her father she needed to move out from Lilith's and get away from her and he had helped her look at flats and offered her financial support as well as offering to provide any deposit needed, but Jo would renege on this before it would happen and remain with Lilith. On one occasion when Jo had been planning to leave Lilith, Jo's father remembers Lilith actually came and collected Jo from her father's and took her back home, Jo quietly complied and went with her.

16.12 Jo father described that Lilith was nice as pie when he first met her, but he never really trusted her as she seemed very controlling of Jo. He reports that throughout the duration of her relationship with Lilith, Jo would turn up with cuts and bruises, which he believed at the time were caused by her sporting activities; kick boxing and hockey, but now he questions this.

16.13 Jo's father recalled a time he went to visit Jo at the home she shared with Lilith and noticed how on edge and nervous Jo seemed. Lilith was not present but was due back and Jo seemed really conscious of this. Jo was scared that Lilith would find out that he had been there, as she did not like Jo seeing her family.

16.14 He described Lilith as very domineering and recalls that she would not let Jo keep many of her belongings in their home, as so he had lots of her property stored at his home for her.

16.15 Jo's father explained that Lilith really blamed everything that happened between her and Jo on Jo's binge drinking. He recalls that Jo managed to quit drinking for a period of time but one summer it was Lilith who actually encouraged Jo to drink again.

16.16 Jo's use of alcohol had caused tensions to arise in her relationship with her father, and on one occasion, Jo's eight year old half sister had found Jo passed out drunk in

the family bathroom at her father's home. Words were exchanged between Jo and her father and the relationship suffered.

16.17 Jo had disclosed to her half-brothers, who lived abroad, that she felt abused and controlled by Lilith when she would speak to them. Her family also noted that her alcohol consumption seemed to increase drastically after she began her relationship with Lilith. This also coincided with a decline in Jo's mental health according to her mother.

16.18 During the Police investigations several witnesses were spoken to including friends and ex-partners of Lilith. They, in the main, report the relationship between Jo and Lilith as 'volatile' and although verbal arguments and shouting were overheard or witnessed, physical assaults were only really known about through Lilith recounting events to them.

16.19 Jo was described as really nice when sober and easy to get on with, it was when she was drunk that these witnesses state she changed, and her behaviour could become aggressive and challenging.

16.20 **Summary of information from ex-partner Lilith**

16.21 Following discussion with the Panel and Jo's family, it was agreed that the Chair would seek Lilith's input in this review process. As outlined in section 7.8, the Chair/Author spoke with Lilith on the telephone about her relationship with Jo. The author also reviewed a summary of the Police interview held with Lilith, which further informs this section of the review.

16.22 Lilith said that she and Jo had been in a relationship since September 2019, and Jo had moved in with Lilith and Lilith's ex-partner, who was still residing with her at the time.

16.23 Lilith then purchased a property with a female friend and her, the friend and Jo all moved in to this new home together. Lilith stated that at some point whilst living together, Jo and the friend had had a physical fight, Jo hitting the female and the female hitting Jo back causing a cut to Jo's eyelid.

16.24 Of note is that when this friend was spoken to by Police as part of the investigation following Jo's death, she denied there ever being any violence, thus contradicting Lilith's account. This friend moved out of the address and left Jo and Lilieth living together.

16.25 Lilith stated she charged Jo rent of £350 per month to help cover bills, but said she would often pay for Jo to go out, or get takeaways, as Jo never had any of her own money.

16.26 Lilith said that the problems within her and Jo's relationship all came down to Jo's drinking. Lilith said that Jo would drink excessively, lie about it and steal from her

and others to pay for alcohol. She said that Jo would use the delivery app 'Just Eats' to order alcohol to be delivered to their home during the day.

16.27 Lilith said she had tried her best to help Jo to stop drinking and that Jo was abusive and violent towards her because of the alcohol she consumed. Lilith said she had connected with a previous partner of Jo's who had also experience Jo as abusive.

16.28 Lilith stated she did to understand why she had been investigated by police as she was the victim in the relationship and had only ever tried to help Jo. Lilih stated that Jo's parents would not help her, despite numerous requests from her and Lilith for them to do so.

16.29 Lilith said that Jo would often go off after an argument about her drinking and not return for days at a time, hence why Lilith had not reported her missing straight away on the 12th of December but waited until two days later. She also stated that by this point her and Jo were staying in separate rooms due to the breakdown of their relationship.

16.30 Lilith stated that Jo was violent towards her on numerous occasions throughout their relationship, yet she did not report this to Police or seek medical attention. Lilith stated injuries that Jo had sustained were all caused by her participation in kick boxing.

16.31 Lilith did not present as overly emotional or upset during the call and clearly articulated her position as a caring partner who had tried her best to help a "difficult and challenging addict". Lilith took no responsibility for any of the volatility or challenges within the relationship and identified Jo as the sole source of the problems they had encountered, primarily because of her alcohol addiction and the effect this had on her mood and behaviour.

16.32 **Summary of information known to the agencies and professionals involved**

16.33 Jo had contact with a range of agencies throughout the duration of her relationship with Lilith; a summary of this is presented below.

16.34 **Carlisle City Council (Housing)**

16.35 All contacts with Jo directly related to housing advice being sought intermittently through a period dating from 21st November 2019 to 24 September 2021, when the case was closed due to a loss of contact.

16.36 Throughout this 22 month period, contact with Jo was limited; she was directly spoken to on three occasions (despite multiple attempts at ongoing contact evidenced); and was seen alone and in person on 21st November 2019 when an initial housing needs assessment interview was undertaken.

16.37 Part of this interview includes an in-depth assessment of all safety risks including domestic abuse, and immediate needs to determine risks, key vulnerabilities and priority need in line with legislation and good practice.

16.38 As Jo was assessed as having no local connection, and she stated she was not homeless throughout, her case was managed as a low priority, low need, housing advice case only as no statutory duty was owed under the relevant legislation.

16.39 The Council was unaware that Jo was a victim of domestic abuse until advised as part of the Domestic Abuse Related Review.

16.40 Jo did not disclose any domestic abuse or personal safety concerns when asked directly by the Officer(s) in any of the interviews, assessments and contact points reviewed.

16.41 **Cumbria Constabulary (Police)**

16.42 Cumbria Police had relatively detailed knowledge of the relationship between Jo and Lilith. As outlined in the chronology section of this report, there were around 15 different calls for service prompting officers to speak with Jo and Lilith, either together or separately between 19.08.2019 and Jo's death/discovery.

16.43 Information held by Police identified Jo and Lilith as both suspects and victims of domestic violence and abuse within the relationship.

16.44 On most police attendances Jo was highly intoxicated through alcohol and on one occasion Lilith was described as drunk. Jo had been arrested for driving offences involving alcohol, which also highlighted her ongoing battle with this addiction and resultant risk laden behaviour and vulnerability.

16.45 Jo's mental health challenges were known to police, and information from almost every contact with Jo provided an insight into her ongoing experiences with low mood, suicidal ideation and deliberate self-harming behaviours, including cutting and alcohol abuse.

16.46 No positive criminal justice outcome was achieved in relation to offences disclosed by Jo or Lilith as they would either withdraw the allegation they had made or decline to provide enough information to pursue an effective criminal case.

16.47 **National Probation Service (NPS) – {Cumbria and Lancashire CRC}**

16.48 At the time of the contact with Jo the service was provided by Cumbria and Lancashire CRC, this organisation no longer exists. They had different operating policies and during the last two years the National Probation service has implemented a lot of change. This will be expanded upon in the Analysis section.

16.49 Jo first became known to the probation service when she was sentenced to a 12 month Community Order on 03.01.2020 with requirements of Unpaid Work and Rehabilitation Activity Requirement Days. The index offence was Drink Driving. Jo attended and complied with the Order which she completed on 02.01.2021.

16.50 During the period of supervision there were noted concerns around mental health and domestic abuse. During this period COVID impacted on the delivery of probation

services, therefore, remote contact such as telephone calls took place in line with the exceptional delivery model, which was implement by HMPPS.

16.51 Jo was then further sentenced to a 24 month Suspended Sentence Order on 26.07.2021 with Rehabilitation Activity Requirement days, an Alcohol Treatment Requirement and Unpaid Work. The offence was for Drink Driving committed on 30.05.2021. Jo was still subject to probation supervision at the time of her death.

16.52 The probation service where aware of difficulties and abuse between Jo and her partner. From when she was first interviewed at Court there are records indicating that Jo was in a relationship with Lilith and she described that this was a new relationship and there were some control issues, i.e. Lilith would check through her phone. Jo indicated that she would have preferred to have her own accommodation but struggled due to COVID-19 and finding somewhere herself to live.

16.53 From the onset of her involvement with probation the recognised risk assessment tool OASys identified Jo as 'both a perpetrator and victim of domestic abuse'.

16.54 Jo had told to her Probation Practitioner that she had commenced a relationship with Lilith very quickly at the start of the COVID-19 pandemic and intimated that she would not be in a relationship with Lilith if she had her own place to live.

16.55 Jo also stated that Lilith had Post Traumatic Stress Disorder, which made her more supportive and understanding of Jo's own mental health issues.

16.56 The probation service accessed police intelligence information in relation to domestic abuse and specifically the probation practitioner was aware of domestic abuse call out in August 2021; an incident when Jo was reported to have bitten Lilith's face.

16.57 There was a multi-agency meeting, which probation attended at the time of incident. It was assessed by the supervising officer that Jo minimised the abuse in the relationship but that she did want to engage with work around this.

16.58 It was also highlighted that there had been abuse in Jo's previous relationships and there was evidence of controlling and coercive behaviour in her current relationship from Lilith. There was information shared that Jo had been assaulted by Lilith and required hospital treatment. Overall, there was clear recording by the probation practitioner indicating knowledge of the relationship with Lilith and the domestic abuse issues.

16.59 The following were identified as needs for Jo; accommodation, alcohol misuse, emotional wellbeing and relationships. During the first period of probation supervision appointments focused on her mental health and alcohol use.

16.60 During the second period of supervision Jo was made the subject of an Alcohol Treatment requirement. She was working with Unity to address her alcohol use and was encouraged to speak to her GP about her mental health and ask for a referral to the Community Mental Health Team.

16.61 The Probation Practitioner also introduced the 'Turning the Spotlight'[25] programme to Jo, advising her to self-refer to the programme, and completed a safety plan with her, recognising she was at risk of domestic abuse.

16.62 **Recovery Steps Cumbria (Unity)**

16.63 The treatment and support Jo received from Addiction Services when operating as 'Unity', under Greater Manchester Mental Health Trust (pre October 2021) was in regard to her alcohol use and the clinical and psychosocial interventions that were provided and delivered. This contact took place between **06.07.2021 and 20.10.2021.**

16.64 A full assessment was undertaken with Jo on **06.07.2021**, which included a disclosure that her relationship with her partner was 'volatile'.

16.65 Jo said that when drinking wine and beer she experienced lower inhibitions and increased anger which caused conflict with partner and admitted that she hits her "self-destruct" button. Jo expressed things at home were improving and described partner Lilith as supportive but was finding the strain of Jo difficult.

16.66 Jo remained signed off from work and said she was struggling to fill time. Jo said she had family nearby but described the relationships as strained.

16.67 Jo said that she could be impulsive and erratic and admitted that thoughts of self-harm and suicide could come in waves. Jo expressed awareness of who to contact and what to do when she had concerns regarding her mood. She explained she was in regular contact with Crisis Team, open to Liaison and Diversion and due to receive support with First Steps[26].

16.68 Jo had disclosed her pending court date for drink driving offences and was very anxious about this. She expressed a goal to work towards abstinence but also explained that she still wanted to drink as she enjoyed it.

16.69 Importantly, Jo accepted that her mental health was the underlying issue and stated that once this was under better control she could look at abstinence but until then she felt the need to access support to manage the risk and reduce her use.

16.70 Jo's probation practitioner informed Unity of the incident in late August where she was reported to have bitten her girlfriend's face.

[25] Turning the Spotlight (TtS) is a project commissioned by Cumbria PCC and delivered by Victim Support to support families experiencing conflict, violence and abuse. Built on a package of programmes, they offer extensive support to those who have experienced (and/or have perpetrated) standard to moderate levels of violence and abuse. TtS works with individuals who have offended or caused harm, or are at risk of offending or causing harm, identified as standard or medium risk. https://www.cumbria.gov.uk/eLibrary/Content/Internet/537/6683/6687/17362/44200155955.pdf

[26] First Steps – Renamed in 2023 to NHS North Cumbria Talking Therapies. A service for adults which offers support with low mood, anxiety, stress and coping with difficult times.

16.71 Jo's mental health was explored in full, the information gained was included in her risk assessment, which was updated throughout her treatment. The focus on Jo's health and wellbeing was a priority for the service and was apparent when reviewing the detailed case notes and relevant documentation contained within Jo's file.

16.72 On **30.07.2021** Jo told her worker that she was in A&E with a head injury after tripping over the door mat and said she may need stitches to treat the injury.

16.73 Jo informed her worker that she had recently received a driving disqualification for 40 months and was still drinking up to 3 days per week but felt in control of this and was taking her Acamprosate.

16.74 The last contact with Jo was a face to face appointment on **20.10.2021** Jo disclosed drinking at weekends with her partner, in a controlled way. She said she would only drink beer and would avoid spirits.

16.75 Jo described her mood as 'up and down' and expressed needing to speak to her GP regarding an increase in her Citalopram medication. Jo expressed no recent suicidal thoughts but did disclose some recent self-harm.

16.76 Jo said she continued to live with her partner and expressed no concerns at that time. A plan was agreed that she would continue to try and engage with controlled alcohol use, avoid using spirits and avoid using alcohol for more than one day in row.

16.77 **General Practice (GP) – Temple Sowerby GP1**

16.78 Jo's GP reflected that Jo was well known to the practice, especially to two female GPs. On the surface Jo had a good relationship with the doctors but she would not always take up the support offered. In her late teens/early twenties she started to have problems with her mental health, and this would present with low mood and using alcohol to help her to cope.

16.79 The doctors were aware that there had been some difficulties in her childhood but despite them giving her multiple opportunities she did not open up to the GPs about this. It was noted that she had missed several appointments in her childhood e.g. immunisations. She appeared to have good family support later in her life, but the GP was aware that there was some tension between Jo, her mum and step dad.

16.80 When questioned directly Jo was often guarded in her responses and there were limited disclosures about past trauma and how it had impacted her. It is worth noting that because the practice is small they were able to provide her with good continuity of care and did everything they could to develop a trusted relationship with Jo but despite this there were some issues in her life that she did not want to discuss.

16.81 Jo's physical health was described as good. Her problems with mental health seemed to escalate around the time when she was preparing to leave home to go to University. In 2017 there was a query about whether or not she had ADHD. She presented with low mood and anxiety and was started on the antidepressant,

Sertraline. It was also noted at that time that she had started to use alcohol to help her to cope with stress.

16.82 In 2018, while at University she presented again with mental health issues and alcohol abuse. This time she was started on another antidepressant, Fluoxetine.

16.83 When she returned to Cumbria from Leeds her mental health appeared to have deteriorated. This was evidenced by her involvement with the mental health crisis team and Unity, the substance abuse service at that time.

16.84 The GP saw Jo as a troubled person but also someone with full mental capacity and who engaged fully with services when they offered to help her. The practice would regularly call Jo in for a review if they received a letter from the crisis team or Unity and they would chase her up if she did not respond straight away. There was good evidence of safety netting, Jo did not have a specific Safety Plan in relation to her suicidal ideation.

16.85 In relation to suicide risk Jo normally contacted the practice only after a mental health crisis when she was starting to feel better.

16.86 Jo had never mentioned during her contacts with the practice that she was in a same sex relationship. Her partner was registered with a different practice. The first time that her GP was aware of a relationship was in a letter from the mental health triage team. This raises a question about whether or not Jo had fully come to terms with this during her life. Jo never attended any of her appointments at the practice with her partner. When she was asked who was supporting her she would normally talk about her family rather than her partner.

16.87 The practice never received any information that would indicate that Jo was a victim of domestic abuse. One of the letters from mental health service indicated that there had been an incident where she had an argument with her partner while under the influence of alcohol. The letter also said that Jo and her partner were keen to make their relationship work.

16.88 The practice had not received any information from the Police about any domestic abuse incidents, or any notifications that Jo had been discussed at MARAC.

16.89 The GP said that if they had known about the domestic abuse then this would have changed the care and support that they gave her. She wished she had known so that she could have done more to help.

16.90 The ability to provide continuity of care is easier in small, rural practices like Temple Sowerby than it is in very large urban practices like the one in Carlisle.

16.91 Even though Jo had a Carlisle address, and the practice had told her that because she was now living outside their area she would need to register with a new practice, they continued to see her whenever she needed because they recognized how vulnerable she was. Recognising vulnerable patients on a GP list is easier for small rural practices as they have greater opportunities to get to know their patients

as they tend to stay with one practice for many years and the practice is often at the heart of the community.

16.92 **General Practice (GP) - Eden Medical Practice GP2**

16.93 Jo was dual registered with two GPs, the newer practice to Jo being Eden Medical practice where she registered in September 2020. This was the practice where Jo had her sutures removed from her laceration above her right eye on 13.08.2021.

16.94 The Practice never received a report regarding the suturing of Jo's facial injury. It was therefore unknown to the Practice which service she attended, where this was, whether the injury was clearly explained and documented and whether any safeguarding concerns were raised at the time.

16.95 It does not appear however, even due to lack of medical report, that any discussion was held with Jo about the cause of the injury and no routine domestic abuse questions were asked or recorded when she attended the practice to have these sutures removed.

16.96 Domestic abuse was not discussed by or with Jo in her dealings with this GP practice. The practice was aware of Jo's mental health challenges, the fact she had contact with the crisis team and her engagement with Unity for alcohol support.

16.97 Despite there being reference to the Crisis team, both from Jo herself stating she was awaiting contact, and from the 111 report, Eden have no letters/reports from the mental health services. As a GP service, it is very difficult to know when they have not received reports or letters; they do not get sent copies of all Crisis team contacts for example, as often these can be daily and the surgery would receive a report either at the end of their input, which would outline all the input the Crisis team had, or the Crisis team would make contact if there were concerns or medication changes that were needed. As Jo had mentioned she had contact or was awaiting contact from mental health services, the practice report that they would have been comfortable that she was getting the support she required.

16.98 **Victim Support (VS)**

16.99 Victim Support did not receive any referrals for Jo as a victim of domestic abuse. There were three domestic abuse related referrals received but they listed Lilith as the victim and Jo as the suspect.

16.100 Victim Support feel that had the information held by Jo's probation practitioner been shared at the MARAC by the Probation representative, then this would have given them the opportunity to explore Jo's experiences as a victim, complete a DASH risk assessment and potentially offer appropriate support and advice. They were unable to do this as only had information that Jo was the primary/only abuser in the relationship with Lilith.

16.101 **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)**

16.102 Jo had telephone contact with CNTW in August 2019, following 111 contact in relation to suicidal thinking. She stated that she had returned to Cumbria earlier that day, following the breakdown of her relationship with her girlfriend of five months in Leeds.

16.103 Jo shared that she had difficulties with alcohol and had previously accessed support via Unity. She said that her alcohol use had caused difficulties in her previous relationships, studies and employment.

16.104 Jo also shared that she had experienced depressed mood and suicidal thinking intermittently since her teenage years and had managed distress by episodic self-harm in the form of making superficial cuts or burns to her skin. She said she had last experienced suicidal thinking in 2018, on the breakdown of her previous long term relationship however she felt her mood had improved on meeting her most recent ex-girlfriend.

16.105 Jo attended A&E two days later reporting suicidal thoughts and voice hearing. At assessment she shared that her previous relationship had ended causing a deterioration in her mental health, but she denied any previous history of abuse. No evidence of major mental illness was found with a diagnosis of "Adjustment Disorders with mixed anxiety and depressive reaction in background of Chronic induced depression" was given following review by the team Consultant Psychiatrist.

16.106 Jo reported intermittent binge drinking in response to emotional dysregulation yet no indicators for dependence were found on questioning. Jo reported having alcohol free days. It was recommended that she contact Unity for support regarding her alcohol use. Jo subsequently either cancelled or missed multiple planned appointments with the home treatment team but did engage in some crisis and contingency and safety planning prior to her discharge to GP services.

16.107 Jo contacted the team either for prescription requests or to report suicidal ideation and seek support.

16.108 In January 2020, Jo self-referred to 'First Step' Talking Therapy and engaged with the assessment appointment. She reported that she attended Unity for support with alcohol use and shared that she was serving Community Service with Probation supervision and in receipt of support from Step Change for her financial difficulties. She requested support for anxiety and depression and was placed on the waiting list for Cognitive Behavioural Therapy.

16.109 In contact with the Crisis Team on the 28th of January 2020, Jo shared that she had contacted the Police upon arguing with her partner and leaving the couple's home, but she was unable to get to her mother's home as planned. She was in the company of the Police at the time of the call, and they had agreed to transport her to her mother's home.

16.110 Jo did not respond to attempts to contact her from First Step to commence the Cognitive Behavioural Therapy and she was subsequently discharged in May 2020.

16.111 Jo contacted the Crisis Team in September 2020 reporting depressed mood and anxiety symptoms and asked that she be prescribed an antidepressant. She was advised to approach her GP. She reported that she had resumed alcohol use but planned to reengage with Unity. Her relationships were discussed with her, and she described supportive friends and family. She denied she was in mental health crisis.

16.112 In June 2021, Jo spoke with a crisis clinician reporting a resurgence of low mood and anxiety which she attributed to a recent stressor of being charged with driving whilst under the influence of alcohol. She reported that she planned to reengage with Unity and was encouraged to do so.

16.113 Lilith contacted the team later that evening reporting that Jo was using alcohol regularly and was refusing support however following repeated contact, Jo engaged with the Crisis clinician and agreed to attend a face to face assessment. Jo cancelled the appointment the following day and a new appointment was scheduled however following further telephone contact, Jo reported alcohol withdrawal symptoms and was advised to seek advice from her GP or A&E.

16.114 On the evening of the 22nd of June 2021, CNTW were notified that the Police had been contacted two days prior reporting Jo as missing from home by Lilith. On her return, the couple had argued, and the Police had been contacted. In telephone contact with the Crisis Team, Jo reported ongoing anxiety and low mood and was advised to seek support from her GP for medication. Jo denied crisis but agreed to a referral to Lighthouse for emotional support.

17 ANALYSIS

17.1 **This part of the report examines how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It considers whether different decisions or actions may have led to a different course of events.**

17.2 It is evident from Jo's contact with agencies and disclosures made to family members and trusted professionals that she felt she was being controlled and abused by her partner Lilith. She also admitted struggling repeatedly and significantly with poor mental health and using alcohol as a coping mechanism.

17.3 Jo blamed herself for a lot of the problems she experienced, she seemed to have a low opinion of herself and lacked self-esteem. She knew how to seek help initially, when in crisis, but would then struggle to maintain any meaningful engagement with support services in the mid to longer term.

17.4 Research published in May 2020 which examined the barriers to support among women who experience substance use and domestic abuse in the UK revealed that,

as expected, being involved in a psychologically abusive relationship was significantly and positively correlated with alcohol-related problems, which were in turn significantly and positively correlated with suicide proneness. Additionally, the intimate partner psychological abuse involvement-suicide proneness link was significantly mediated by alcohol-related problems.[27]

17.5 Considering Jo's experiences with domestic abuse, mental health difficulties and alcohol misuse, this section analyses how these factors may have contributed to her tragic death. This in turn will help identify lessons which need to be learnt by agencies, based on Jo's experiences, to improve the response given to any other individuals who may find themselves in a similar situation.

17.6 Jo faced numerous concurrent challenges and vulnerabilities which overlapped and intertwined, making her ability to access and engage in relevant, appropriate and bespoke interventions and support pathways extremely difficult.

17.7 Given that the backdrop to many of these challenges Jo was facing was a global pandemic, which impacted society at every level, we can begin to understand the context within which Jo's last few years of life was experienced.

17.8 In 2020 some research was completed which highlighted that *"Domestic abuse victimisation is a common experience among women with problematic substance use, but support provision for both issues is siloed within the UK*". This was the first piece of research from the UK to explore, in-depth, women's journeys through support for their co-occurring substance use and domestic abuse victimisation. The research is important as it demonstrates the barriers they must overcome.

17.9 The women involved in the research reported the biggest barrier was the disconnect between substance use and domestic abuse support, including a gap in the communication of information. This resulted in them having to choose which of their needs to seek support for. None of the women received support for their combined experiences, and most of the women never received support for their domestic abuse experiences alone.

17.10 These findings reflect some of Jo's experiences as whilst she did disclose being a victim of controlling behaviour and intimate partner abuse to some professionals in her life, she was never provided with a support pathway which might have helped to further recognise, address and understand the risk this posed her or her what her options for changing/escaping the situation may look like.

17.11 From evidence the panel have seen it appears that the primary presenting issue, which for Jo was most often mental ill health or extreme alcohol intoxication, was the one which received the sole focus from professionals. This meant that the

[27] Lamis DA, Malone PS, Langhinrichsen-Rohling J. Involvement in Intimate Partner Psychological Abuse and Suicide Proneness in College Women: Alcohol Related Problems as a Potential Mediator. Partner Abuse. 2010 Apr 1;1(2):169-185. doi: 10.1891/1946-6560.1.2.169. PMID: 20544000; PMCID: PMC2882695. https://www.emerald.com/insight/content/doi/10.1108/add-09-2019-0010/full/html

domestic abuse was either not recognised, enquired about or seen as a priority in terms of the support Jo may need.

17.12 Another relevant piece of research which relates to this Review is '*Exploring perspectives on living through the COVID-19 pandemic for people experiencing homelessness and dealing with mental ill-health and/or substance use: qualitative study'*[28]. One of the key themes this research identified was the lack of support and exacerbation of mental health and substance use difficulties during the pandemic.

17.13 Research participants spoke about how they felt that access to mental health and substance use support had been deprioritised while health and care system efforts focused on combatting COVID-19. They reported feeling frustrated that they could not access mental health and substance use support during this period, and, in some cases, this left them feeling helpless. Some spoke about how they considered suicide in response to not being able to cope with their emotions and adversity.

17.14 The research showed that *"the isolation, loneliness and reduction in services brought about by the pandemic resulted in some relapses in participants' mental health and substance use."* Due to the timing of events which led to Jo's tragic death, the impact that the pandemic had on services and how they were provided was a key feature of the analysis section of this Review.

17.15 The panel considered the typology of abuse/abuser and whether we would be able to determine from information gleaned throughout this review what the dynamics of abuse were in Jo's relationship with Lilith.

17.16 Renowned Emeritus Professor of Sociology Michael P Johnson[29] argues that intimate partner domestic abuse is not a unitary phenomenon, instead he delineates three major and dramatically different forms of domestic abuse, namely intimate terrorism, violent resistance and situational couple violence. He goes on to explain that failure to distinguish among these types of intimate partner abuse can lead to misunderstanding of the inter relational dynamics at play and in turn the associated risks.

17.17 Johnson's different types of abuse can be understood as follows:

17.18 **Intimate terrorism** involves the general exercise of coercive control and involves one partner being controlling, and often violent, whilst the other is not controlling. This form of abuse is related to a power imbalance whereby psychological and emotional abuse is used to entrap victims through chronic fear of consequences of not complying to the abuser's direct or tacitly implied 'rules'.

[28] Adams, E.A., Hunter, D., Kennedy, J., Jablonski, T., Parker, J., Tasker, F., Widnall, E., O'Donnell, A.J., Kaner, E. and Ramsay, S.E. (2024), "Exploring perspectives on living through the COVID-19 pandemic for people experiencing homelessness and dealing with mental ill-health and/or substance use: qualitative study", Advances in Dual Diagnosis, Vol. 17 No. 1, pp. 1-13. https://doi.org/10.1108/ADD-06-2023-0014 https://www.emerald.com/insight/content/doi/10.1108/add-06-2023-0014/full/html

[29] https://en.wikipedia.org/wiki/Michael_P._Johnson

17.19 **Violent resistance** is a reactionary response by victims of intimate terrorism and can involve planned or unplanned acts of violence towards the abuser. Violence in the face of intimate terrorism may arise from a variety of motives including self-defence, retaliation or to facilitate escape.

17.20 **Situational couple violence** does not involve any attempt on the part of either partner to gain control over the relationship. The violence is situationally provoked as the tensions or emotions of a particular encounter led someone to react with violence. Immediate and genuine remorse is often felt when situational couple violence occurs.

17.21 Johnson states that '*the critical distinctions among types of violence have to do with general patterns of power and control…the difference is in the general power and control dynamic of the relationship, not in the nature of any one assault.*'[30]

17.22 When considering Jo's use of intimate partner violence and abuse, alongside her own experiences of suffering it, through the lens of Johnson's typologies the typology which most aligns based on the evidence seen by the panel is violent resistance.

17.23 The panel found no evidence of Jo's violence towards Lilith being motivated by, or committed within the context of, a desire to obtain and maintain power and control over Lilith. Jo's addiction to alcohol, fear of being made homeless by Lilith, low self-esteem and ongoing mental health crises are more conducive to a person reacting to or resisting abuse than strategically abusing in a manipulative way.

17.24 There is no evidence from Lilith that Jo was ever controlling or sought to create a power imbalance in the relationship, in fact Lilith only ever spoke of physical abuse, and generally in the context of an argument and whilst Jo was intoxicated.

17.25 When considering Jo's abuse as reported by Lilith, this appears to be borne out of situational triggers, events and external factors rather than a strategic desire for power and control.

17.26 When considering Jo's voice, and how she experienced her relationship with Lilith, we see a difference in the nature of the abuse described. Jo explicitly used the word 'controlling' and depicted a home environment where Lilith was very much in the position of control, demanding to check through Jo's phone, not liking her seeing her family, shaming her for drinking whilst at times encouraging the same.

17.27 Jo also described Lilith as being quite emotionless and lacking in empathy, unable to understand or support Jo in an appropriate, caring way. Whilst at the beginning of the relationship, Jo had described Lilith as a 'support' and someone who understood her, this changed over time and so may indicate either a deliberate withdrawal of

[30] Michael P. Johnson - A Typology of Domestic Violence; intimate terrorism, violent resistance and situational couple violence.

support or the cessation of a façade used in the initial stages of their relationship by Lilith to present herself as caring and compassionate.

17.28 When viewed through Johnson's typologies of abuse, these characteristics Jo described align most to the intimate terrorist, who uses coercion and control to acquire and maintain power over their partner.

17.29 The Review's purpose is not to assign blame or apportion responsibility to the subjects involved, but to highlight where appropriate and necessary considerations were lacking, and how they could have potentially helped change the course of events in Jo' life had they been made.

17.30 What was absent in all the evidence seen by the panel throughout this review was any reference to the typology of abuse being experienced between Jo and Lilith.

17.31 This meant that Jo never received support as a victim and never had the opportunity to speak with a domestic abuse specialist and better understand the relationship, or her and Lilith's roles within it.

17.32 Without consideration, differentiation and assessment through the lens of abuse typologies it can prove harder for professionals to understand and thus effectively respond to domestic abuse.

17.33 The analysis section, divided by agency, addresses the terms of reference and the key lines of enquiry which were identified by the panel as being relevant to Jo and her experiences. It is also where examples of good practice are highlighted.

17.34 **Carlisle City Council (Housing)**

17.35 Jo attended a housing advice drop in session at the Civic Centre in Carlisle on 21st November 2019, where it was established she had a local connection to Eden District Council (EDC), as she was originally from Appleby. Jo advised that she had been to University in York and had only moved to Carlisle in August 2019 and was living with friends. Jo advised she was struggling to pay the lodging requested by her friends as did not have a current job and was not yet in receipt of benefits (she had made a claim for Universal Credit).

17.36 Jo also disclosed that she had alcohol issues which she was seeking help with from Unity (local drug and alcohol services at that time, now Recovery Steps). Jo also advised that she had a history of self-harming and suicidal ideation. The Officer interviewing Jo asked detailed questions to determine risks and personal safety aspects including asking Jo directly about domestic abuse.

17.37 Jo explained that she wanted independent housing, as such, advice was given around registering on the social housing register (Cumbria Choice), and how to make a claim to cover her rent charges once her benefits were established.

17.38 It was explained to Jo that EDC would have a duty to assist her with accommodation if she needed it due to her local connection; Jo stated she was able and happy to

remain living with friends. Following the interview, contact was made on Jo's behalf with EDC to make them aware of a possible referral back to area should Jo want this, and her circumstances change. This is over and above what is expected and shows good practice from the Officer concerned.

17.39 Later that same day, another Officer was alerted to Jo who was slumped on the floor near the front of the Civic Centre building and was noted as being under the influence of alcohol and described as being difficult to rouse. As Jo stood up she stumbled and hit her head on a concrete planter; the Officer called an ambulance and stayed with her until paramedics attended and took Jo to the hospital. This again is an example of good practice.

17.40 On 6th December 2019, Jo contacted the Officer by telephone to advise she wished to return to her mother's address but said she hadn't spoken to her for a while and asked if the Officer could make the initial contact with her. As such, the Officer made several unsuccessful attempts to contact Jo's mum on the number Jo provided; via telephone, voicemail and texts. Jo was advised of this and again her housing options were discussed with her including the options around emergency accommodation which Jo declined, stating she could remain living with her friends. Attempting to mediate on behalf of the client shows another example of good practice.

17.41 The only other direct contacts from Jo were via two online self-referrals completed stating she was seeking `*non urgent housing advice as staying with friends following a non-violent relationship breakdown*' (13.03.2020 and 02.09.2021). Following both referrals repeated contact attempts were made to Jo, via a range of means (e.g. telephone, email, text) but were all unsuccessful. In line with practice for assessed advice cases, they were closed within 3 weeks due to no further contact being made.

17.42 The nature of the relationship between Jo and Lilith was not known to the Council throughout the period reviewed. The only information relating to domestic abuse (noted on 16th September 2021), related to a request to MARAC for a contact number check for Jo, who was identified at that meeting as the perpetrator. The case officer made several unsuccessful attempts to contact Jo and as such closed the case in line with agreed practice. This additional contact check, and the check with Unity to determine up to date contact details, is another example of good practice shown.

17.43 **Good practice**

17.44 As outlined in the analysis above there were several examples of good practice noted from the Housing Officer, this included proactively contacting EDC to alert them to Jo and the fact she may need their assistance with housing; providing a humanistic and compassionate response when locating Jo outside and intoxicated, supporting her to get safely to the hospital; trying to support Jo by trying to contact her mother on her behalf to discuss Jo staying there.

17.45 Overall the limited contact the council had with Jo was in line with the expected standard and often exceeded it.

17.46 **Cumbria Constabulary**

17.47 Cumbria Constabulary first had contact with Jo in **August 2019** as she had called 111[31] feeling suicidal. This is the point they become aware of Jo's mental health and alcohol challenges. The officers in attendance helped her to contact support services and took her to her mother's home. The officers acknowledged these as support needs/vulnerabilities and completed a SAF VA. This was not onward shared to Adult Social Care or other services as Jo had already been in contact with the SPA line when with officers.

17.48 Cumbria Constabulary were first aware of Jo's association with Lilith during an incident in early **October 2019** when she was arrested for drink driving and Lilith was front seat passenger in the vehicle at the time. On this occasion Jo was over three times the legal limit. There is no record that indicates that Jo and Lilith were in a relationship, or that this was explored or asked by the officers involved.

17.49 Research completed by SafeLives in 2018 indicated that both statutory and non-statutory services were missing opportunities to identify LGBT+ victims, survivors and perpetrators of domestic abuse.

17.50 Furthermore, it found that LGBT+ victims and survivors were experiencing high levels of risk and complex needs before they accessed support and needed support tailored to their needs and circumstances.

17.51 A victim's sexual orientation or gender identity can sometimes be targeted as part of the abuse and societal attitudes and lack of inclusion were preventing LGBT+ victims and survivors from accessing the support they needed to get safe and recover and also meant that perpetrators weren't being identified and stopped at the earliest opportunity.[32]

17.52 This failure to ascertain and record the relationship between Jo and Lilith could indicate some unconscious bias towards same sex couples and suggest that heterosexism or heteronormativity may have factored into this omission.

17.53 The next contact the police had with Jo was in the following **January 2020** when she was arrested for stealing alcohol from a shop. She made no mention of domestic abuse or her relationship with Lilith during this contact.

17.54 In all three contacts now, alcohol has been highlighted to police as an issue for Jo. She also disclosed the breakdown of her relationship with her ex-partner from Leeds, struggling with depression and that she had a history of deliberate self-harm. Police again completed a SAF VA form, and this was shared with Adult Social Care three days later.

[31] https://111.nhs.uk/ NHS 111 is a triage service, available in England only.

[32] https://safelives.org.uk/wp-content/uploads/Free-to-be-safe-report.pdf

17.55 Ten days later the first domestic abuse related incident involving Jo and Lilith was reported to police. NHS 111 contacted the police to report a suicidal female (Jo) outside a supermarket. She had told them she was homeless and was feeling suicidal because she had been in an abusive relationship.

17.56 Police attended and spoke to Jo who told them she'd had a verbal argument with her partner Lilith as Lilith had accused her of drinking and she asked her to leave and wanted nothing more to do with her. Jo told officers that she didn't feel safe in Carlisle as she was now homeless. She said was currently out of work and had no money.

17.57 Jo explained to police that she had ongoing relationship issues. She described Lilith's behaviour as unpredictable and said that Lilith was having 'trust issues' surrounding Jo's alcohol consumption.

17.58 Police transported Jo back to Appleby and contacted the SPA line on the journey. Jo said she was taking anti-depressant medication for her anxiety and depression but had no current thoughts of self-harm or suicide, despite previously having had such thoughts. The SPA line arranged to contact Jo the following day.

17.59 Lilith was visited by police and explained to officers that she and Jo had been having relationship issues lately due to Jo's problems with drink. She explained that Jo had been drinking again that day, and so she had asked her to leave. Lilith was frustrated, as she said that Jo had not contributed financially towards meals or bills since she had moved in. Lilith stated that this is what has led to them arguing and her kicking Jo out.

17.60 Officers completed a SAF including a DASH RIC with Jo; this recorded 2 positive responses and was graded as 'Standard Risk'. As was procedure at the time, as there were no criminal offences, and a 'verbal only' domestic argument with standard risk, the information was not onward shared, and the record was filed.

17.61 From the content of the police log and the Safeguarding Adults Form, the police IMR author felt that other DASH RIC questions could have been answered 'yes' including recent separation, feeling frightened/unsafe and potential control as she was forced out of the shared home. These are high risk indicators and may have changed the risk level assessed had they been considered and applied by the officer completing the DASH with Jo.

17.62 From analysis of the Police contact with Jo and Lilith, the police were generally effective at both identifying and responding to the needs and risks faced by the Jo during contact with her.

17.63 It appears that the risks identified by officers initially were recorded as low and so this resulted in a lack of a holistic approach, with individual officers responding to individual events and not viewing the situation as escalating or pattern forming. It was later that the risk assessments officers completed indicated a medium or high risk and a more holistic approach was considered, including the instigation of the

MARAC process, albeit with Lilith as the victim and Jo as the suspected abusive party.

17.64 Following an incident report to police on **22nd June 2021** whereby a verbal altercation occurred between Jo and Lilith, the Street Triage Team (STT) were utilised and spoke with Jo. The STT are a department within the police who deal with incidents where Mental Health crisis is ongoing and the officers within the department take responsibility for managing the safeguarding concerns, including signposting and referrals.

17.65 What is of note in relation to the contact with the STT however is that they recommended to Jo she seek relationship counselling from 'Relate'. Where any type of domestic abuse is indicated, as there had been with Jo and Lilith, joint couple's counselling or therapy is rarely safe or advisable, as it can be used by abusers as a performative space to further shame and control the victim by manipulating the professional and positioning themselves as the one being abused.

17.66 Whilst the STT officers were acting in good faith and signposting to services they felt may help Jo, based on what she described, checks should have been conducted on police systems which highlighted the previous domestic history and this aspect explored more with Jo, rather than recommending a service which could potentially increase risk and harm. Had STT officers used their professional curiosity to try and better understand the relationship issues and considered completing another DASH with Jo, then this may have proved an opportunity to signpost Jo to specific support as a potential victim of domestic abuse, rather than someone experiencing relationship issues due to her own mental ill health and alcohol abuse.

17.67 On **30th August 2021** Police were called to Jo's address due to reports from a neighbour who had seen Lilith headbutt her, causing Jo to fall and suffer injuries to her legs and forehead. Lilith had been seen leaving the scene in a vehicle.

17.68 Police attend and speak with Jo, who stated she was being abused, but due to her intoxication, it was difficult to establish a clear understanding of events. The reporting neighbour was seen by police as Jo was taken to their house when she was headbutted and waited there until police arrived and was seen by police a paramedics there. It does not appear that a witness statement was taken from this neighbour, despite being the initial caller and identifying themselves as a witness to the assault on Jo.

17.69 Whilst this was happening, Lilith presented to a nearby police station to make a counter allegation against Jo, telling them that Jo had bitten her to the face. Police decide to arrest Jo and record a crime of 'actual bodily harm', showing Lilith as the victim. A crime was also recorded by police for Lilith headbutting Jo. Both crimes were closed with 'no further action' (NFA) and they were not connected to each other on the system, which they should have been. The panel has seen no record of any enquiries pursued in relation to Lilith headbutting Jo. This may indicate a bias

towards sober witnesses, or those who appear more credible and articulate upon police attendance.

17.70 Many victim-survivors of domestic abuse will turn to alcohol as a coping mechanism, an escape from the psychological pain and entrapment they suffer. This provides an opportunity for abusers to further control and manipulate the narrative with professionals and others present (witnesses, neighbours etc) as an they can appear in a far more controlled, calculated and credible way than the intoxicated victim.

17.71 Family members recalled an incident of Lilith actively encouraging Jo to drink alcohol, this is another commonly seen tactic of people who seek to harm and control their partners. Shaming and blaming the victim for drinking, whilst concurrently encouraging it and mocking any abstention causes a confusing and destabilising situation for people addicted to alcohol. This in turn leads to lowered resilience and thus enhanced compliance with the harmful partner's narratives. It is possible that this was what Jo experienced.

17.72 All agencies must ensure this pattern of behaviour and presentation, common to domestic abuse incidents, is understood and the knowledge applied in practice when attending calls for service. If this is not acknowledged and recognised, we risk further isolating victims, criminalising them and effectively colluding with the person responsible for the abuse.

17.73 The Police IMR author noted that the DASH risk assessment process required improvement, including training and ensuring that officers were conducting the process when in attendance at the scene, not afterwards when not still with the victim.

17.74 Since this review the training element has been reviewed there has direction provided by senior leadership for supervisors and management to ensure that the DASH risk assessments are completed at all domestic incidents attended.

17.75 The IMR author also felt that the way in which police understand and utilise a 'trauma-informed approach' should be improved, the panel shared this view. The provision of longer training inputs relating to completion of the DASH would allow officers to understand the reasons for and importance of conducting the assessment at the time of the incident and understanding what trauma informed means in practice.

17.76 The biggest barrier that Police encountered during contact with Jo and Lilith was that neither party provided much detail or supported a prosecution against the other.

17.77 There were multiple occasions where offences were alleged by both parties but follow up enquiries resulted in the victim in that case not wanting to provide further detail and making the decision that they wanted no further action. This frustrated

police investigations and provided limited opportunity for a positive outcome through the justice system.

17.78 Evidence-led prosecutions could have been considered using other sources of evidence, such as witness testimony, Body Worn Video (BWV), hearsay evidence etc. A prosecution leading to a successful conviction could have mandated support services and work with partner agencies, such as probation to enhance the support being provided.

17.79 Police guidance provided by the College of Policing's 'Approved Professional Practice' (APP) recommends that *"Police officers should not base a decision to arrest or not to arrest on the willingness of a victim or witness to testify or otherwise participate in judicial proceedings. Officers should focus efforts on gathering evidence in order to charge and build an evidence-led prosecution case that does not rely entirely on the victim's statement. Officers should ensure that they read and use the Joint NPCC and CPS Evidence Gathering Checklist for use by Police Forces and CPS in Cases of Domestic Abuse."*

17.80 The guidance also makes it clear that in domestic call outs it can be challenging to identify the correct person to arrest, to this end it is recommended that;

17.81 *"Officers should avoid jumping to conclusions about which of the parties in the relationship is the victim and which the perpetrator. This applies to all types of relationships, whether heterosexual, same sex, transgender or familial (non-intimate partner). They should probe the situation and be aware that the primary aggressor is not necessarily the person who was first to use force or threatening behaviour in the current incident. They should examine whether:*

a. *the victim may have used justifiable force against the suspect in self-defence*
b. *the suspect may be making a false counter-allegation*
c. *both parties may be exhibiting some injury and/or distress*
d. *a manipulative perpetrator may be trying to draw the police into colluding with their control or coercion of the victim, by making a false incident report*

17.82 *Counter-allegations require police officers to evaluate each party's complaint separately and conduct immediate further investigation at the scene (or as soon as is practicable) to determine if there is a primary perpetrator. If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the party being arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one."*[33]

17.83 The other barrier to effectively engaging that officers faced during contact with Jo was her level of intoxication. Having viewed the BWV from the incident on **30th August 2021**, the IMR author identified that Jo's high levels of intoxication resulted

[33] https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/first-response#determining-the-primary-perpetrator-and-dealing-with-counter-allegations

in her providing conflicting and confusing accounts, with the true picture not being established. There were occasions where follow up visits were conducted but these resulted in Jo denying any offences or any form of domestic abuse.

17.84 It is well known that victim of abuse from their partner or family members will often retract and withdraw complaints, deny previous allegations made or minimise the situation to professionals. This can be for myriad reasons but commonly is due to fear of repercussions or 'making things worse' with their abuser, being coerced or manipulated to believe it is their fault and they are to blame, or a wish not to criminalise their loved one and to 'repair the relationship'.

17.85 From all the evidence seen during the process of this review, all of the above mentioned reasons were relevant to Jo at various points in her contact with police and thus indicate a need for frontline officers ensure they are equipped not only with the understanding of the motivation behind victim reluctance to engage or support action, but the alternatives that should be offered when this is encountered. This should include providing the victim/potential victim with information about what other services, particularly non statutory services, can provide, assist and how they can be accessed. They can offer to make a referral on the victim's behalf rather than relying on the victim to proactively reach out or self-refer at a time that they are likely to need that additional support.

17.86 Due to the increase in the frequency of calls for services leading up to Jo's death, police officers were more cognisant of the issues she faced, including mental health and alcohol abuse, but the panel have seen no evidence that the police understood the root cause of the problem. There is a consideration to be had about how officers can expand on that during interactions with subjects and conduct a deeper dive to try and establish the real issues. This is effective 'Professional Curiosity' and so the analysis suggests that this an area for development needed by the frontline and their supervisors when responding to calls for service, and in particular calls involving those such as Jo who might be facing multiple disadvantages.

17.87 **Good practice**

17.88 The panel and Police IMR author found evidence of good practice in the responses from Cumbria Constabulary, and these are highlighted in the following paragraphs.

17.89 The use of a Senior Investigating Officer (SIO) to conduct a peer review of the ‘missing from home’ (MFH) report to ensure that all reasonable lines of enquiry were identified and followed up was good practice. It allows for the opportunity for further investigation should lines of enquiry be recommended that had not been identified by the original SIO.

17.90 The force’s stance on standards in attendance at incidents of domestic abuse is an area of good practice noted during this review. The senior leaders in the force have been instructed to utilise briefing time to ensure the message around best practice for DA cases are shared with officers. This includes;

- completion of the DASH risk assessment at the scene or safe place,
- always speaking to any children present to see what a day in their life looks like,
- being proactive in referring cases to CPS to secure charges and
- considering other tactics if the victim is not supportive of a criminal justice outcome, such as pursuing an Evidence-Led Prosecution (ELP)[34], issuing DVPN/DVPOs[35], stalking protection orders (SPOs)[36] etc.

17.91 The use of body worn video (BWV) is good in cases of domestic abuse in general. This practice has not been utilised in this case, but in general, BWV evidence has been used to good effect.

17.92 Implementation of a Family Liaison Officer (FLO) during the missing from home period, the subsequent inquest and DHR. The FLO's objectives were to update Jo's mother and Lilith during the course of the investigation to ensure relevant information sharing from consistent contact.

17.93 The implementation of mandated training for front line officers, called DA Matters[37].

17.94 **National Probation Service (NPS) – {Cumbria and Lancashire CRC}**

17.95 At the time that Jo was engaged with probation in 2020 and 2021 the service was being run by Cumbria and Lancashire Community Rehabilitation Company (CLCRC) this organisation no longer exists. CLCRC had different operating models and management. Probation started the process of reunification in June 2021, taking six months to fully re-emerge as the National Probation Service (NPS). It is important to reflect that the NPS are now operating differently and during the last two years the Probation service has implemented a lot of change.

17.96 Jo was sentenced to a 12-month Community Order on 03.01.2020 with requirements of Unpaid Work and Rehabilitation Activity Requirement (RAR) Days. The index offence was Drink Driving.

17.97 Jo attended and complied with the Order which she completed on 02.01.2021. During the period of supervision there were noted concerns around Jo's mental health and domestic abuse. During this period COVID impacted on the delivery of probation services, therefore, remote contact such as telephone calls took place in

[34] https://www.college.police.uk/support-forces/practices/evidence-led-prosecution-checklist-domestic-abuse-cases

[35] Domestic violence protection notices and orders provide short-term protection for domestic abuse victims.https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/using-domestic-violence-protection-notices-and-domestic-violence-protection-orders-make-victims-safer

[36] The Stalking Protection Act 2019 introduces a new civil Stalking Protection Order (SPO) which can be sought by the police and are an effective means of managing an alleged suspect through the use of prohibitions and/or positive requirements as well as imposing notification requirements on the suspect.

[37] Domestic Abuse (DA) Matters is a programme of activity originally developed to help policing organisations to enhance the knowledge and skills of their workforce. It helps those who act as first responders (and champions who manage or supervise them) to improve the police response to domestic abuse.

line with the 'exceptional delivery model', which was implemented at the time by HMPPS.

17.98 Jo was then further sentenced to a 24 month Suspended Sentence Order on 26.07.2021 with requirements for RAR days, Alcohol Treatment and Unpaid Work. The index offence was again Drink Driving, committed on 30.05.2021. Jo was still subject to probation supervision at the time of her death.

17.99 During her periods of probation supervision Jo had two supervising officers, both of whom were Probation Service Officers (PSOs) as opposed to qualified Probation Officers (POs) who hold the Professional Qualification in Probation (PQiP). Jo seemed to have developed trusted relationships with both her PSOs; she made honest and candid disclosures about her mental health difficulties and how she experienced her relationship with Lilith.

17.100 Probation identified and recorded Jo as *'both a victim and perpetrator of domestic abuse'*. There was no assessment completed around who the primary abuser was in the relationship, or what type of abuse was being used or experienced by Jo, i.e. it might have been that Jo was using violent resistance in response to Lilith's coercive control; this presents an entirely different risk dynamic and therefore risk management plan than if Jo had been using coercive control against Lilith for example.

17.101 Jo did disclose that Lilith was 'controlling' and would monitor her by checking through her phone.

17.102 Jo was clear she would rather live on her own, but due to COVID, felt pressured into moving in with Lilith, and this had been very soon after the relationship commenced. Jo even suggested that she would not be in a relationship with Lilith if she had somewhere else to live.

17.103 The controlling behaviour Jo described and Lilith's ownership of the home Jo lived in are indicative of a power imbalance in Lilith's favour. When combined with Jo's continued struggles with alcohol, her regular mental health crises, economic/financial challenges and her low self-esteem, it becomes clear that the relationship dynamics could represent a hierarchical structure. Such as often seen in relationships where an abuser uses their increased power to amplify their control and uses the victim's insecurities and 'flaws' as psychological weapons against them. The more the victim accepts the blame for any relationship issues, the easier it becomes for abusers to control the narrative and present as credible, whilst positioning the victim as discreditable, unreliable and the source of the problem. This often extends to the victim then being labeled as the abuser, as the true abuser manipulates the narrative and 'switches roles'.

17.104 Abusers who do this often present themselves as some kind of 'saviour', who are trying their best to 'help' the victim and are in fact suffering themselves consequently. This type of manipulation extends beyond the victim, and can incorporate friends, family and professionals. This in turn creates additional barriers

for the victim as their support network is compromised and escaping the abuse seems like an unrealistic possibility.

17.105 Jo's financial difficulties were compounded by being signed off from work sick before eventually losing her job due to the drink driving conviction; of note Lilith was present with Jo when she was driving whilst over the prescribed limit of alcohol. Jo was not named on the mortgage with Lilieth and often struggled to pay the agreed rent to Lilith, this left her vulnerable to homelessness and gave Lilith even more of a position of power due to the economic disparity between the pair. Whilst Lilith gave, she was also able to take away and would reportedly regularly threaten this; potentially therefore wielding the economic threat as a way to further control and coerce Jo. It also appears from Jo's father's testimony that he sought to support her financially but was unable to do this because of what he perceived as Lilith's control over Jo.

17.106 It is with this in mind that professionals working with anybody who discloses abuse, directly or indirectly, must ensure they are aware of and alert to these nuanced and complex dynamics. A lack of understanding of the varying nature of abuse and abusers leads to the oversimplification of situations as behavioural mutuality, reciprocal abuse or being considered a 'toxic relationship' between two parties who are 'both as bad as each other'. Such persistent, societally perpetuated tropes can lead professionals to ignore risks, abandon professional curiosity and make assumptions about the level of threat, risk and harm presented.

17.107 As part of Jo's Sentence Plan one of her identified objectives was recorded as *"I will have reduced the occurrences of DV where I am the perpetrator and will engage with support as the victim, reducing police call outs and risk of harm."*

17.108 When considering this as an objective, it clearly places responsibility for the abuse with Jo, confusingly labelling her as both a perpetrator and a victim in one sentence. Part of the objective includes an expectation for her to 'engage with support as the victim' but there is no record of what this support was. There is no record that Jo was ever informed about, signposted to or offered to have a referral made on her behalf to a specialist domestic abuse service. So quite what the support she was supposed to engage with was, remains unclear.

17.109 By using the acronym 'DV' (Domestic Violence) in the plan there is an inherent linguistic implication that this only includes physical acts of harm and abuse. This can be misleading and minimise the impact and effects of psychological, economic, sexual abuse and coercive controlling behaviour.

17.110 Another dangerous aspect of the objective wording used is the expectation that Jo should be responsible for '*reducing police call outs'*. This is dangerous because we know that less than 24% of all domestic abuse experienced gets reported to Police[38] and so if a target is reducing Jo's police call outs, this could well prevent her calling police for help if she needed it.

[38] https://refuge.org.uk/what-is-domestic-abuse/the-facts/

17.111 Vanessa Bettinson, a professor at Northumbria University who specialises in coercive control and the criminal justice system explained in a recent article for 'Open Democracy'[39] that "*We need to be asking questions about the reality of a victim's experience and what options she had. Women who have experienced the police responding in a certain way, such as by arresting the victim, or siding with the perpetrator, will not call the police again*." She goes on to describe *"This is something called social entrapment, where women become trapped in abusive situations because they don't think they have a route to safety."*

17.112 The PSOs used the OASys assessment[40] with Jo and deemed her to pose 'medium risk to known adult (partner/ road users)'. The SARA[41] tool was also used with Jo and the risk rating given in relation to the risk Jo posed as a perpetrator was also assessed to be medium. What was lacking was the use of any risk assessment tool which assessed the risk posed to Jo as a victim of domestic abuse from Lilith, such as the Domestic Abuse, Stalking and Honour Based Violence Risk Identification Checklist (DASH RIC).[42]

17.113 Had this been completed with Jo then a far better understanding of the nature of the abuse she had briefly described would have likely been achieved. This would have then allowed both Jo and her probation practitioner to understand the risk to her and seek appropriate support to create a meaningful and relevant safety plan. It would also have allowed for a better understanding that Jo was a victim and would have therefore opened up pathways to support from DA services or Victim Support who were trained in the 'typologies of abuse' and would therefore be better equipped to recognise how to help keep Jo safe.

17.114 Probation services at the time did not provide staff training around the typologies of abuse, so the concept was not understood by practitioners working with people on probation. The 'Advanced Domestic Abuse e-learning' training does cover typologies; however this was not rolled out to staff until 2025 so would not have been in place at the time of Jo's death.

17.115 The probation service also does not use the DASH RIC or any other victim specific risk assessment tool; their assessment models are perpetrator focused and

[39] https://www.opendemocracy.net/en/domestic-abuse-victims-criminalised-tory-law/

[40] OASys (Offender Assessment System) is a risk and needs assessment tool used by probation and prison services to understand why individuals offend and what can be done to help them stop. It involves a questionnaire and interview to identify risk and criminogenic needs. The tool is designed to be used in conjunction with sentence plans to manage risks and needs.

[41] The SARA assessment, or Spousal Assault Risk Assessment, is a tool used to evaluate the risk of domestic violence in individuals suspected of or being treated for spousal abuse. It uses a structured guide with 24 items to assess various risk factors, including the nature and severity of the abuse, and supervisor violations. The SARA can help determine the level of risk an individual poses to their partner, children, or other family members.

[42] https://static1.squarespace.com/static/63585aa01220164be2e387b2/t/65a82ce5e47f867b140872ed/1705520358604/DASH+2009+2024.pdf

therefore start with the assumption that the person on probation is the abuser and not the abused.

17.116 For a service whose primary purpose is to support and manage people convicted of crimes, this is to a degree understandable, but when considering how closely connected being a victim of domestic abuse is to criminality and how high a proportion of women in prison and on probation have been or are victims of domestic abuse, a more informed perspective must be employed by the service nationally.

17.117 In an open letter to the UK Government: *'Provide Support, End Unfair Criminalisation of Women'* from Sonya Ruparel, CEO of Women in Prison[43] the following quote from a Service manager working for the charity is included and states; *"One of my Case Work Team has 23 women on her probation case load. Of those 23, at least 20 have experienced domestic abuse or are currently in an abusive relationship."*

17.118 This highlights the prevalence of co-occurring domestic abuse victimisation and some form of criminality. For Jo it was drink driving that counted as her index offence for both of her periods of contact with Probation, yet how her drinking was linked to her experiences of domestic abuse, and the relationship with Lilith, was evidently not explored. This highlights a lack of professional curiosity in terms of the connection between the various complex needs Jo was trying to cope with, and the tendency to silo them off and seek specific support for each in isolation of the other, e.g. substance abuse support, community mental health support, support to reduce *her* harmful behaviour.

17.119 Due to this compartmentalisation of Jo's needs within her sentence plan objectives, there lacked an assessment of the risk posed to her by Lilith, in terms of physical or psychological, especially important given Jo's previous suicidal ideation. Whilst the probation practitioners did seem aware of Jo's risk of suicide and self-harm, this does not seem to have been captured or considered within the context of domestic abuse.

17.120 There was information recorded that Jo was both victim and perpetrator, yet she never risk assessed or supported as a victim despite her disclosures to her PSOs of suffering abuse from Lilith. At the MARAC held in September 2021, the probation representative did *not* share this information, failing to inform the other professionals that Jo had disclosed being abused by Lilith or highlight the traits of controlling coercive behaviour Lilith was exhibiting towards Jo such as demanding to check her phone. This is particularly relevant as at the MARAC it was Lilith who was presented and recorded as the victim of abuse from Jo, and so this interpretation was never corrected. Had it been, then consideration of the possibility of 'situational

[43] Women in Prison is a national charity that delivers support for women affected by the criminal justice system in prisons, in the community and through their Women's Centres. They campaign to end the harm caused to women, their families and our communities by imprisonment.

couple violence', 'coercive control/intimate terrorism', and 'violent resistance' might have been given and the true nature of the abuse dynamics better understood.

17.121 This presents a significant missed opportunity for Jo to be assessed as a potential victim herself and offered the appropriate advice, support and validation moving forward.

17.122 Another agency, with knowledge of the abuse typologies and who utilise the DASH RIC, could have then been actioned to engage Jo as a potential victim following the MARAC. This could have then potentially enabled her to leave Lilith's house and the relationship, find her own independent accommodation, access specialist, informed support and look to work on her complex needs more holistically with a suitable qualified individual.

17.123 Partly due to the COVID19 pandemic and changes to working practice, home visits were reduced by Probation around the time of Jo's sentence. However, Jo never had a home visit during either of her periods of probation involvement. A home visit can provide an important insight into the home environment and relationship dynamics of the person on probation; they are excellent tools to aid professional curiosity and can allow for a far better understanding of the lifestyle and wellbeing of the person subject to supervision.

17.124 The Probation IMR author found no evidence of any home visits being completed with Jo and was left unclear as to why this was. Since Jo's case was being managed policy changes have occurred resulting in every case now having a home visit.

17.125 Given the proximity of the Probation offices to the Council's Housing department, a joint appointment was never suggested or actioned for Jo, despite housing being high on her list of priorities. The panel representative for Housing felt that had this been actioned, something which is quite common practice in terms of cross-agency working, then the council's housing team would have helped identify the domestic abuse and supported Jo to look at being accommodated with their support in relation to this. This represents another missed opportunity.

17.126 **Good Practice**

17.127 Probation staff appear to have developed positive relationships with Jo, and she was offered a female Probation Officer. The rapport that both PSOs seem to have built with Jo allowed her to really open up, share her concerns, feelings and emotions and make disclosures about the domestic abuse she experienced and how she felt about her relationship with Lilith.

17.128 The MARAC action allocated to Probation was completed and case note recording was sufficiently completed.

17.129 Jo had had a sentence plan and contingency plan, via OASYs and both of Jo's PSOs seemed to understand Jo's risk profile in terms of risk of harm posed, as well as the dynamic risk factors and sentence planning which was focused on these areas.

17.130 The PSOs appear to have been operating in a non-discriminatory way and offered Jo appropriate flexibility, noting her personal circumstances and the challenges she faced. They recorded no unacceptable absences across her sentence period and 10 acceptable absences. They offered a total of 25 appointments, of which Jo attended 15.

17.131 The PSOs supported and encouraged Jo to seek alternative accommodation, providing guidance and direction around where to go and how to access Choice Based Lettings (CBL) and included 'bidding for properties' as a part of her sentence plan.

17.132 **Recovery Steps (formerly Unity)**

17.133 The treatment and support Jo received from Addiction Services when operating as Unity, under Greater Manchester Mental Health Trust (pre-October 2021) was in line with expectations, policies and procedures regarding her alcohol use and the clinical and psychosocial interventions that were provided/delivered.

17.134 While a full assessment was undertaken with Jo, which then formulated a comprehensive risk assessment and a person-centered recovery plan, it does not appear that a DASH RIC tool was used following Jo's disclosure that her relationship with her partner was 'volatile'.

17.135 A further red flag for the service could have been raised when Jo stated she didn't want either her partner or family to know of or be a part of her treatment and recovery programme.

17.136 Jo's mental health was explored in full, the information gained was included in her risk assessment, which was updated throughout her treatment as appropriate. The focus on Jo's Health and Wellbeing was a priority for the service and is apparent when reviewing the detailed case notes and relevant documentation contained within Jo's clinical file.

17.137 During Jo's time in treatment, there was a recommissioning of services, which also included a period of limited-service provision to allow for the transfer of case records, staff training and TUPE processes to be implemented. On 1st October 2021, Recovery Steps Cumbria was the name of the addictions service operating within Cumbria, which is a partnership between Humankind Charity and The Well Communities.

17.138 The area of Brief Intervention work, which is the pathway that Jo was being managed under, was subcontracted to The Well Communities. During this time the service was undergoing a period of significant transition, it can be deduced that the support offered to Jo was limited.

17.139 The transfer of service provider was a key contextual factor for consideration when undertaking the analysis of contact with Jo and it is important to note the significant pressure on both staff and the service during this period.

17.140 **Good Practice**

17.141 Interventions delivered to Jo were in line with national guidelines and were evidence-based. A holistic and trauma informed approach was adopted with Jo when she first entered treatment, this was affected only at the point of transfer of services.

17.142 Good liaison and communication were evidenced with the National Probation Service, in the management and monitoring of Jo's Alcohol Treatment Requirement.

17.143 **General Practice (GP) – Temple Sowerby GP1**

17.144 Jo was well known to the practice, especially to two female GPs. On the surface Jo had a good relationship with the doctors but she would not always take up the support offered.

17.145 Both GPs have a good knowledge of trauma informed care but when questioned directly Jo was often guarded in her responses and there were limited disclosures about any past trauma and how it had impacted her. It is worth noting that because the practice is small, they were able to provide Jo with good continuity of care and did everything they could to develop a trusted relationship with her.

17.146 When asked by the IMR author if the GPs had ever considered Jo to be a vulnerable adult, they explained that she was definitely seen as a troubled person but that she had full mental capacity and engaged fully with services when they offered to help her.

17.147 The practice would regularly call Jo into the practice for a review if they received a letter from the crisis team or Unity (Recovery Steps) and they would chase her up if she did not respond straight away.

17.148 There was good evidence of safety netting, but Jo did not have a specific Safety Plan in relation to her suicidal ideation.

17.149 In relation to suicide risk Jo normally contacted the practice only after a mental health crisis when she was starting to feel better.

17.150 Jo had never mentioned during her contacts with the practice that she was in a same sex relationship. Her partner, Lilith, was registered with a different practice. The first time that her GP was aware of this relationship was in a letter from the mental health triage team. This raises a question about whether or not Jo had fully come to terms with this during her life. Jo never attended any of her appointments at the

practice with her partner. When she was asked who was supporting her, she would normally talk about her family rather than her partner.

17.151 The practice never received any information that would indicate that Jo was a victim of domestic abuse. One of the letters from the mental health service indicated that there had been an incident where she had an argument with her partner while under the influence of alcohol. The letter also said that Jo and her partner were keen to make their relationship work.

17.152 The practice had not received any information from the Police about any domestic abuse incidents, or any notifications that Jo had been discussed at MARAC. Her GP stated that had they had known about the presence of domestic abuse as this would have changed the care and support that they gave her. Her GP said that she wished she had known so that she could have done more to help.

17.153 When asked if there were any opportunities to ask 'routine enquiry' questions about domestic abuse, Jo's GP felt that in retrospect this could have been done but as letters talked about her partner being a protective factor this was not considered.

17.154 There was no evidence that the COVID19 pandemic affected Jo's access to health care from the practice. If one of the GPs was away, then the other would be available to provide Jo with support if needed. It is worth noting that the ability to provide continuity of care is easier in small, rural practices like Temple Sowerby than it is in very large urban practices like the one in Carlisle.

17.155 Even though Jo had a Carlisle address and the practice had told her that because she was now living outside their area she would need to register with a new practice, they continued to see her whenever she needed because they recognised how vulnerable she was. Recognising vulnerable patients on a GP list is easier for small rural practices as they have greater opportunities to get to know their patients as they tend to stay with one practice for many years and the practice is often at the heart of the community.

17.156 There was evidence of good multiagency working. Letters were received from mental health services and the substance abuse service, and the practice took appropriate action to ensure that Jo was followed up and supported. There was no evidence however of any multi-agency discussion about Jo, despite evidence of escalating concerns around her mental health.

17.157 There was also no evidence of the domestic abuse concerns being shared with the GP practice.

17.158 **General Practice (GP) - Eden Medical Practice GP2**

17.159 Upon analysing the contact Jo had with the practice, where carried out, risk assessments were thorough with clear safety netting. There is never any

documentation to say that Jo lacked capacity or sounded as if she was under the influence of drugs or alcohol.

17.160 Reviews were communicated verbally, were followed up with text messaging and Jo was contacted when she missed the appointment on 03.11.21. Interestingly, the appointment booked for 03.11.21 was following a telephone encounter on 02.11.21 in which Jo described possibly having a urinary tract infection. She specifically asked for a face-to-face for examination before starting antibiotics. However, when she did not attend the planned appointment, the GP contacted her by phone and Jo spoke said she thought she might be pregnant; this demonstrates a clear miss match of information in the consultations which were less than 24 hours apart. GPs do not always manage to follow people up who have not attended and so this indicates that the GP had some concern, given previous interactions with Jo. This demonstrates a level of curiosity, enough to reach out and contact Jo.

17.161 The IMR author highlighted that discussing domestic abuse is very difficult over the telephone as the Clinician would not be confident that Jo was alone and free to openly talk.

17.162 The panel felt however, that given the fact that Jo described to the GP on the call that she had experienced a 'blighted ovum' five weeks earlier and now suspected she maybe pregnant, this should absolutely have been further explored during the call by the GP.

17.163 There are additional factors in Jo's case which make the lack of further questioning and exploration here particularly concerning;

a. Jo was addicted to alcohol and struggled to control her harmful drinking; she was even prescribed medication to help with the impact her alcohol misuse was having on her physical health (Thiamine).

b. Jo was in a same sex relationship; whilst the GP has stated they were personally unaware of this, this was a fact outlined in a letter received by the practice from one of Jo's interactions with another agency, so was effectively information 'known and available' to the practice.

   This could mean that Jo had fallen pregnant through consensual sexual activity outside of her relationship, this in turn may have posed an increase in the risk of harm posed to Jo from her partner had they found out. As this was never explored, there is no way of ever knowing, but it is something that must be considered by the panel as a possibility in a review designed to highlight learning to improve practice.

c. Given that there is no evidence to suggest any previous discussions had been held around family planning or contraception with Jo, the possibility that the pregnancy, either from the 'blighted ovum', or the one she suspected she may be currently experiencing, was as a result of an assault should have been

considered. This may have been particularly relevant for Jo as her drinking often left her in situations where she had significantly reduced cognition and coordination and was therefore less able to keep herself safe.

d. Jo had a long-documented history of experiencing mental health crises and struggling to maintain emotional stability and consistent engagement with services in place to support with both her addiction and mental health challenges.

e. As there was no previous record on Jo's notes about the pregnancy she mentioned having terminated earlier that year, or the blighted ovum from five weeks prior to the call, it would have been reasonable to expect that this be explored by her GP. Asking Jo how she knew she had a 'blighted ovum' and what treatment if any she had received would have helped identify the support she may require and any other services she may have engaged with in relation to it.

   It is a very specific medical term for Jo to use, and so it suggests that she had heard it from somewhere; either she had been diagnosed with it elsewhere, or it is something she had researched herself online. As this is the only record where there is mention of a 'blighted ovum', and was self-declared by Jo, the panel will sadly never be able to ascertain the accuracy of the statement or how it all affected Jo.

f. Pregnancy is something that could have hugely impacted upon Jo, physically and mentally and yet no evidence has been seen that demonstrates whether Jo was asked if it was planned, or how she felt about the possibility she may be pregnant. Consideration for the unborn child, should she have been pregnant, was also a requisite factor given Jo's previous suicidal thoughts and feelings and addiction issues.

g. Pregnancy loss can be extremely difficult to cope with and yet how this had impacted Jo, either following the termination she disclosed had occurred earlier in 2021, or from the more recent blighted, ovum does not appear to have been explored either.

17.164 When all of these factors are taken into consideration, the lack of professional curiosity and any additional clinical questioning of Jo does not seem justified or wholly mitigated by the fact that the discussion was over the telephone rather than in person.

17.165 The fact that Jo had mentioned the prior termination, the blighted ovum and a potential current pregnancy indicate that she was able to talk about them to some degree, and she should have been given the opportunity to explore the contextual health and wellbeing issues surrounding these disclosures with the GP during the call on 03.11.21. This represents a missed opportunity to have safeguarded and supported Jo at a critical time.

17.166 Domestic abuse was something never disclosed by Jo to the practice, but it could have been identified if further discussions were had with her around the A&E attendance and the presentation for the suture removal on 13.08.21.

17.167 Clinicians would have been trained in domestic abuse but the only episodes within the surgery where this could have been truly discussed would have been on 13.08.21 when Jo attended for suture removal, although it is not documented whether she attended alone or not. The eye injury was potentially from a domestic assault, but as the practice had no report shared with them and Jo disclosed nothing in the consultation, it remains unclear whether the health care assistant (HCA) discussed the mechanism of the injury or reached out about potential domestic abuse. This was the first and only contact between Jo and that HCA so it would depend upon rapport and interaction; it may well be that the mechanism was discussed, and a plausible answer was given but was not documented.

17.168 Certainly, there is an issue here either with note keeping or with not having professional curiosity to ask about the injury.

17.169 The other face-to-face consultation was on 04.08.21 when Jo attended for bloods. Again, it is not documented if she attended alone and the HCA may not have been aware of the reason bloods were requested. The HCA did not document any concerns from the interaction.

17.170 With regards to the documentation of who is present, the practice have a template to populate for all child attendances which includes this information, but not for adults. There is no formal policy or procedure in place to document adults attending, but often clinicians will document who else is present, but less often will they record when a person attends alone. Anecdotally, the IMR author explained that during the COVID pandemic lockdown, they documented all present in the consulting room, more to help with track and trace, should anyone later test positive for COVID-19.

17.171 Overall, given the resources, the Practice offered a good service to Jo, including the GP following up the missed 03.11.21 appointment with a phone call; given the pandemic, GP surgeries have been extremely busy, and the missed appointment may well have gone without follow up for another clinician's surgery.

17.172 There was potential missed opportunity at the suture removal appointment. Also, due to the way the practice is staffed, reports/letters were not always sent to the same clinician and therefore there was a potential lack in overall sight of Jo's presentations.

17.173 Current workload stress on general practice, made worse by the COVID-19 pandemic, means there are less clinicians working full-time. Therefore, information coming into the surgery regarding a patient is ideally sent to the named GP the patient is registered with. The named GP however is not always the most relevant GP/Clinician as patients are able to choose to see any clinician and often will see different clinicians for different problems.

17.174 Also, consideration must be made for occasions when clinicians are on annual leave as it is not safe to leave reports unread until a clinician returns to the surgery, often letters/reports will be sent to a “buddy” of the usual named GP. The buddy system has had many changes because clinicians have left the surgery or changed sessions. Therefore, a buddy group may have changed part way through the year. When on annual leave, rather than a scheduled day off, the documents are shared out between clinicians present in the surgery on the day the documents come in and this will vary as to when the documents come in and who is in the practice.

17.175 The Wellbeing & Safeguarding lead was also still relatively new in post and was in the process of making policies and procedures more effective, although openly admits this was more focused on children than adults in the initial 6 months.

17.176 The main barrier in this case, apart from the obvious less face-to-face consultations due to COVID, was the miscommunication/failure to receive records; in some cases, information arrived after Jo was seen and reviewed (the Liaison and Diversion team report being the prime example) or was not received at all, even after Jo’s death i.e. the report regarding her eyebrow injury requiring suturing from August 2021.

17.177 The foot and finger injury report from 30.08.21 was as a result of Jo being “pushed over 2 days ago”. This does not mention an eye injury requiring suturing. The report involving the eye injury, must have gone to another surgery or was lost in the system somewhere, as Jo attended Eden Medical Group on 13.08.21, some 17 days before attending A&E with the foot and finger injuries, meaning that a report for this injury must be dated prior to 13.08.21. This may have been due to the fact that Jo was dual registered with Temple Sowerby Practice (GP1).

17.178 **Good Practice**

17.179 The GP involved was proactive with follow up actions and had a clear risk assessment documented following an initial phone call with Jo. The GP also did their utmost to try and keep continuity, at least initially and with the Unity (Recovery Steps) requests for blood tests etc. Based on what was known it was good to see that continuity regarding the medication was also happening towards the end of Jo’s registration with the practice.

17.180 Record keeping in the main was good, although the suture consultation does not list anything regarding the injury/cause etc and no curiosity regarding no external report was triggered and there is very little recorded about Jo's termination, blighted ovum and suspected pregnancy in November 2021.

17.181 The was evidence of good practice and lessons which must be learnt around the importance of professional curiosity, particularly with patients presenting unexpected or unusual symptoms, disclosing medical information not known to the surgery and who are facing multiple disadvantages or complex

17.182 **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)**

17.183 CNTW had numerous encounters with Jo over the period analysed throughout the Review. Most of these related to mental health crises which Jo was experiencing. When follow-up appointments were offered or made, Jo struggled to keep them, and her engagement was poor.

17.184 Jo previously had some contact with Talking Therapy from June to August 2018, however following assessment of her low mood symptoms and some treatment with mood diaries and work around structuring her day / behavioural activation, she disengaged from treatment and was discharged. The records reflect that Jo was contacted by the clinician, when she did not attend sessions, and reported that her mood was improving and intended to continue treatment, but did not attend the subsequent rescheduled appointments.

17.185 CNTW have a 'Did not attend' (DNA) process and it is reviewed on a case-by-case basis and based around Risk. CNTW records show that an unannounced home visit was made to see Jo following a missed appointment with the Home Treatment Team, and she was seen but stated she was busy and could not speak to them. A follow up arranged home visit was made and Jo was present and seen on that occasion.

17.186 The review notes that at Crisis Team contact in September 2020 and again in June 2021, Jo was encouraged to 'self-refer to Unity for support for alcohol use disorder'. The clinician should have made these referrals for her; an issue identified here around not being trauma informed as self-referring is yet another thing for Jo to have to do and puts responsibility and emphasis back onto someone potentially already in crisis and needing support.

17.187 Expected practice would be that this would be completed by the clinician to encourage engagement with the service for psychosocial support and intervention to stop using alcohol.

17.188 Following this review (and concurrent internal reviews) Crisis team clinicians now complete referral to Addictions Services on behalf of all consenting patients. Discharges are reviewed by Team Leads to ensure practice is embedded.

17.189 The review found evidence of routine questioning around relationships, abuse and adverse childhood events, as would be expected, however Jo did not disclose abuse during any contact with CNTW. The review notes that decision making regarding acceptance for treatment, treatment planning and subsequent discharge showed evidence of multidisciplinary review and managerial oversight throughout Jo's contact with CNTW, as would be expected.

17.190 The effects of COVID-19 restrictions on practices increased across several services during the period under review. However, the review notes that Jo had access to

continued support available for her within CNTW mental health services, so this would be deemed not to have significantly impacted on her care provision.

17.191 On contact with Crisis and IAPT services, Jo's assessment included exploration of previous trauma whereby the assessment considered psychological symptoms associated with trauma or that occur alongside it. Jo was asked about previous or current trauma experiences at assessment with clinicians who understood that further exploration was indicated and was therefore planned in the course of treatment for Cognitive Behavioural Therapy in January 2020. Further Crisis Contact was limited to telephone triage, however face to face assessment was planned in June 2021 and had Jo attended, her assessment would have included exploration of past or current trauma.

17.192 Information was shared by the Police in June 2021, regarding Jo's involvement in a domestic incident. This was noted with an 'alert' within the CNTW electronic record.

17.193 The IMR author stated that the alert and subsequent MARAC discussion documentation would alert clinicians in subsequent contact with CNTW, that Jo may be vulnerable to domestic abuse. However, as Jo was listed as the perpetrator at the MARAC, how her vulnerability would be flagged was further probed.

17.194 The panel were informed that an 'alert' is a notification that is shown on the 'demographic' screen of a patient record on the 'RIO' system. This appears as a red triangle, which when clicked on takes the user to a RISK screen. This screen shows on Jo's record the following: *'Listed at MARAC as High Risk perpetrator of DA.'*

17.195 This was an issue of concern for the panel, as this kind of alert could present a skewed view to professionals that Jo poses a danger to others and gives no indication that she may be vulnerable to or suffering abuse herself.

17.196 The IMR author response by clarifying that the alert highlights the MARAC discussion. In Jo's case there was no further documentation reflecting the context of that MARAC discussion.

17.197 The IMR author accepted the panel's concerns regarding how this may bias clinicians to seeing Jo as a threat and a perpetrator solely, however they stated that in contact with CNTW clinicians risk both to and from others is explored with each patient on assessment and nature of relationships would be explored with consideration for patients' vulnerability.

17.198 This issue does link back to earlier analysis regarding the typologies of abuse and the importance of these being discerned and recorded at MARAC. Whether relationships were explored fully or not, if a clinician has this information, as an 'alert' relating to a patient, it will be challenging not to draw early conclusions, and this could then affect their engagement with the patient and potentially be picked up on by the patient.

17.199 It is good practice that there is a system for alerts and that clinicians have that information pertaining to risk easily accessible on patient records; the issue is when that information is incomplete, lacking in nuance and serves to offer an oversimplified and potentially incorrect presentation of risk. This is not an issue for CNTW to correct, but one that the partnership more widely needs to focus on and will be referenced in the latter sections of this report.

17.200 Jo met with Street Triage Clinicians where her relationship was explored. Jo denied domestic abuse, control or exploitation, but shared that her relationship was *'in difficulty but that she hoped to reconcile'*. It is not clear how much professional curiosity was employed here by the clinicians to understand more about how Jo viewed these 'difficulties', but it must be understood that not all victims will resonate with terms like 'domestic abuse' and so denial soes not always mean the absence of abuse.

17.201 In January 2020 IAPT were contacted regarding Jo's referral to their service from Adult Social Care and were informed by Jo that she was also working with Probation Services and Step Change, however the record reflects that information was not sought or shared with these agencies whilst Jo was in treatment, or at her discharge.

17.202 The Panel were informed that the NHS were piloting and rolling out Multi-Disciplinary Team (MDT) monthly meetings to ensure this type of information sharing is routinely occurring.

17.203 The University of Cumbria were evaluating the process which included 'regular callers/patients' and strengthening the response to them by services. This is similar to what happened with Jo, where she repeatedly called in help-seeking to the crisis line over a period of months but was continually referred back to GP for onward care/support.

17.204 The review noted that clinicians recognised Jo's treatment needs, including psychological intervention, to address her mood dysregulation, anxiety and depression and that her intermittent alcohol use would have a negative impact on her mental and physical health.

17.205 Clinicians noted that her ability to engage with mental health services consistently presented challenges for her and directing her to self-refer to Unity was not helpful. The expected practice would be to ensure that a referral was completed with Jo's consent to alert Unity and GP services to promote psychosocial intervention to reduce her alcohol use.

17.206 **Good Practice**

17.207 On Jo's initial contact with the Crisis Team in August 2019, she was offered support to stabilise her mental health and develop a shared understanding of her difficulties. She received support from nurses, occupational therapists and a Consultant

Psychiatrist who discussed her diagnosis with her and made recommendations for further treatment, as she requested.

17.208 During the appointments, Jo was able to reflect on her attachment style and unhelpful coping strategies that she had previously utilised and practiced more positive coping.

17.209 On the Crisis Team telephone contact on the 28th of January 2020, Jo discussed her relationship with her partner, and this was explored by the clinician. Jo reported arguing but denied abuse. The clinician demonstrated professional curiosity, allowing Jo an opportunity to share information or experiences and seek support.

18 CONCLUSIONS

18.1 **This section brings together an overview of the main issues identified, and conclusions drawn from them which will translate into the detailing of lessons learnt in the next section.**

18.2 Jo had experienced low mood and poor mental health since her teenage years and managed distress by episodic self-harm in the form of making superficial cuts or burns to her skin. She starting to use alcohol as a coping mechanism and blamed her alcohol misuse for issues in her relationships, study and employment. Jo struggled with her parents separation and the associated acrimony, feeling 'caught in the middle' at times.

18.3 She had a good relationship with her siblings and enjoyed physical activities such as hockey, kickboxing and walking. She was an amazingly talented artist whose ability to capture subjects with an almost photographic quality was breathtaking.

18.4 Jo started a relationship with Lilith in 2019 and the pair quickly began living together, partly due to the COVID19 pandemic and related lockdowns and restrictions. This seemed to add pressure to the new relationship and Jo's drinking increased. She was caught drink driving with Lilith in the car and was subsequently managed by Probation.

18.5 Jo had many different interactions with agencies between her return to Carlisle from Leeds in 2019 and her disappearance in December 2021. Most of these related to domestic abuse call outs or mental health crises. On the majority of contacts Jo was intoxicated through alcohol.

18.6 Jo disclosed to family members, and both the police and her probation service officers that she was the victim of domestic abuse from Lilith. She described Lilith as controlling, lacking in empathy and regularly threatening to evict her, often telling Jo to leave the address they shared, resulting in Jo sleeping rough.

18.7 Lilith, however, reported that she was being abused by Jo and that Jo would physically assault her when she was drunk. Lilith assigned all of Jo's negative behaviour to her drinking.

18.8 Lilith stated she wanted to support Jo to stop drinking, yet this narrative was contradicted by Jo's father who recalls a video conversation he had with Jo one summer; she was in the garden at the home she shared with Lilith, and Lilith was heard encouraging Jo to drink, even after Jo had declined. Jo's father remembers being shocked by this, and it seeming almost as though Lilith was shaming Jo for *not* drinking and not being fun.

18.9 Police recorded Lilith as the victim and Jo as the perpetrator of domestic abuse in all their records relating to the couple. This is despite there being disclosures by both of abuse from the other, and one occasion where an independent witness reported seeing Lilith assault Jo.

18.10 The review has seen no evidence that any agency who had contact with Jo and Lilith demonstrated knowledge of the 'typologies of abuse' or considered what the dynamics of their relationship were. From evidence seen during this Review it appears that as Lilith was either sober, or the least intoxicated of the pair when seen by police, that she was deemed the most credible and believable and so it was Jo that ended up being arrested. This was true even on an occasion where the initial call to police from a concerned witness reported Lilith had headbutted Jo, causing her to fall to the ground.

18.11 Despite the disclosures made, the information relating to Jo's experiences as a victim of abuse from Lilith were not onward shared. A MARAC meeting took place where the couple were discussed, but no mention was made of Jo's disclosures and so she was viewed as the primary/sole aggressor in the relationship.

18.12 The focus of any referral made by police in relation to Jo focused on her mental health or alcohol misuse, rather than what may be causing these issues such as the home environment, relationship with Lilith and potential abuse she was suffering.

18.13 Lilith told Victim Support that she was not a victim of domestic abuse from Jo, but that Jo had mental health issues and needed some help. Lillith said that the mental health team *'wouldn't help Jo as they said she was drinking too much'*, and Lilith felt like they were *'going round in circles'*.

18.14 This certainly seems to have been a challenge for Jo, and a theme identified in this review was that of dual diagnosis, i.e. co-occurring addiction and mental ill health, and what support agencies provide for people with multiple diagnoses and complex needs.

18.1 Evidence seen by the panel suggests that Jo had an addiction to alcohol and a concurrent mental health problem. This can present the feeling of an inescapable

cycle for individuals caught between drug and alcohol services and mental health professionals.

18.2 According to the Public Health England (PHE) guide from 2017 *'Better care for people with co-occurring mental health and alcohol/drug use conditions; A guide for commissioners and service providers'*[44] co-occurring conditions include mental health and alcohol and/or drug use conditions, including smoking.

18.3 The PHE guide explains that '*It is very common for people to experience problems with their mental health and alcohol/drug use (co-occurring conditions) at the same time. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users [who were in] community substance misuse treatment.'*

18.4 It went on to report that '*Death by suicide is also common, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental health problems…people with co-occurring conditions have a heightened risk of other health problems and early death. We also know that in spite of the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with cooccurring conditions are often excluded from services.'*

18.5 The PHE guide was designed to address this disparity and be used by the commissioners and providers of mental health and alcohol and drug treatment services, to inform the commissioning and provision of effective care for people with co-occurring mental health and alcohol/drug use conditions. It also has relevance for all other services that have contact with people with co-occurring conditions, including people experiencing mental health crisis. The Guide was based on two key aims, namely;

- **Everyone's job**. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
- **No wrong door**. Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

18.6 The PHE guide highlights that alcohol and drug dependence is common among people with mental health problems. High prevalence of these co-occurring conditions has been found among people in the criminal justice system, individuals presenting to hospital emergency departments in mental health crisis and people

[44] https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

experiencing severe and multiple disadvantage. These are populations within which Jo fell.

18.7 The guide found that *'Evidence from service user and provider surveys suggests that people with co-occurring conditions are often unable to access the care they need from both mental health and addiction services. Individuals experiencing mental health crisis may experience difficulty in accessing care due to intoxication (in spite of the heightened risk of harm that this brings)'.*

18.8 Research[45] indicates that one mental health condition may influence another, for example heavy alcohol use may cause depression, or substances may be used as a means of self-medication to relieve the distress of a mental health condition.

18.9 There is much research documenting negative sequelae for those living with co-occurring substance misuse and mental health conditions, as these individuals are likely to experience greater rates of relapse and more hospital readmissions; treatment non-adherence; distorted perception and cognition; greater levels of suicidal ideation; interpersonal stressors and difficulties; social exclusion–unemployment, living alone, or homelessness; more frequent use of aggression and physical violence and associated injury; and/or greater risk of HIV, cardiovascular, liver, and gastrointestinal disease (Horsfall et al., Citation2009; Hunt et al., Citation2013). Furthermore, it is highly likely that overall, their subjective quality of life is poor.

18.10 This reflects many of Jo's experiences and so caused necessary organisational reflection on how the pathways for individuals with co-occurring conditions work in practice and the efficacy of the support provided therein.

18.11 In summary the main conclusions drawn from this Review, and which translated into the lessons learnt and recommendations focus around;

- Lack of professional curiosity.
- Lack of awareness and application of the 'typologies of abuse' and differentiation of types of abuse and abuser.
- Lack of adequate inter-agency information sharing, e.g. within the MARAC setting.
- Lack of clarity around service and support pathway primacy for individuals with dual diagnosis (mental health and addiction issues).
- Bias/unconscious bias around intoxicated witnesses.
- Lack of adequate victim focused risk assessment usage where domestic abuse is disclosed or suspected.

[45] Cleary, M., & Thomas, S. P. (2016). Addiction and Mental Health Across the Lifespan: An Overview of Some Contemporary Issues. *Issues in Mental Health Nursing*, *38*(1), 2–8. https://doi.org/10.1080/01612840.2016.1259336

19 LESSONS TO BE LEARNT

19.1 **This section of the report provides a summary of the lessons which are to be drawn from the case and how those lessons should be translated into recommendations for action.**

19.2 **Any early learning identified during the review process and whether this has already been acted upon is also detailed here. Sub headings listing the relevant agency have been used to present the information with more clarity.**

19.3 **Carlisle City Council (Housing)**

19.4 Carlisle City Council Homeless Prevention and Housing Services align to national good practice within the homelessness sector in delivering trauma informed care (TIC) approaches and psychologically informed environments (PIE).

19.5 During all service team meetings throughout February and March 2023, development sessions were delivered with all Homeless Prevention and Housing Service Managers, and frontline Officers (in line with TIC); to reinforce the importance of professional curiosity specifically in cases where there are protected characteristics which may make someone more vulnerable to abuse, such as in instances where there is a loss of contact and in advance of case closure.

19.6 Homelessness and Housing frontline staff and operation managers all attended an awareness raising / training session specifically focused on LGBT+ domestic abuse victims on 24 March 2023.

19.7 **Cumbria Constabulary**

19.8 **Risk Assessing**

19.9 The force identified that not all DASH risk assessments were being completed at the time of attendance at a DA incident. Officers were completing them retrospectively, using the information gathered at the time. The risk with this practice is that any information gaps may be treated as a negative DASH response and therefore cannot properly inform the risk assessment. The leadership message is to encourage officers to complete at the time and there is a piece of work ongoing with the 'change team' to support this.

19.10 During this review and following research and guidance from the College of Policing[46], the DASH risk assessment tool was replaced by the DARA for frontline officers responding to victim of domestic abuse. DASH (Domestic Abuse, Stalking, and Honour-based Violence) is a multi-agency tool used by various professionals, including social services, to assess risk. DARA (Domestic Abuse Risk Assessment) is a newer tool, primarily for use by police first responders, to identify coercive and controlling behaviour.

[46] https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-Rationale-2022.pdf

19.11 The force ensured this change was supported by providing regular DARA updates to officers in Vulnerability Briefings both before and after DARA was launched.

19.12 The force provided a Vulnerability Briefing in February 2025 where staff and officers were informed that the DASH risk assessment tool was being replaced with DARA. A link to the 'College Learn' DARA training material was shared and completion was mandated.

19.13 The force reminded officers in a follow up Vulnerability Briefing in March 2025 about the change and need to complete the online learning package.

19.14 In the Vulnerability Briefing held in April 2025 reminders were provided to officers of the DARA risk definitions and a link to the app which can be added to officers phones to allow them to have DARA in an easily accessed format at the scene of a DA incident.

19.15 **Body Worn Video (BWV) footage reviews**

19.16 Cumbria constabulary should also consider reviewing BWV following attendance, even if not being used in a prosecution case. In this case, BWV used at the incident on 30th August 2021 shows Jo to be intoxicated, but she does state that she has been abused. She infers that an injury was caused to her that night and a couple of weeks prior.

19.17 Whilst the IMR author felt satisfied that in general Jo had been provided with the opportunity to disclose offences during police interactions with her, but if the disclosure made on the BWV had been properly identified, it should have resulted in more focused work with Jo as a victim.

19.18 **Professional curiosity and a trauma-informed response**

19.19 The IMR author did not believe that the police response was trauma-informed. Each incident and case were based solely on what had been alleged at the time, and action had been taken as a result. The subsequent safeguarding reports were completed and shared with the relevant agencies. They felt that due to the increase in the frequency of calls for services leading up to the death of Jo, police officers including safeguarding officers, were more cognisant of the issues with Jo, including mental health and alcohol abuse but they had not seen any evidence that the police understood the root cause of the problem.

19.20 There is a consideration to be had about how police can expand on that during their interactions with subjects and conduct a deeper dive to try and establish the real issue.

19.21 Scrutiny around professional curiosity being practiced by officers is provided using specialist Evidence Review Officers (EROs) to review cases involving Domestic Abuse.

19.22 Cumbria Police have implemented policies where all DA cases will be subject to an evidential review from officers (rank of Sergeant or above) who have received training in such cases, prior to disposal decisions being made.

19.23 The DA ERO training has recently been updated and amended. There are specific online learning packages and training videos available for sergeants to watch and then they have to submit some reviews to the Criminal Justice unit for checking to check they have understood and taken on the training.

19.24 **Digital forensic enquiries**

19.25 The IMR author felt there was a lesson around better consideration of digital forensic strategies from the outset with each DA case. Although the fact that the suspect's phone in this case has not been reviewed, this appears to have been an oversight and is an exception rather than the norm. The expectation is that in such cases; both the suspect and victim phones (or any other forms of digital evidential opportunities) be submitted to the digital forensics unit together so that they can be downloaded in conjunction with each other in order to prevent any delay in the investigation.

19.26 In June 2024 the force launched 'R.A.P.I.D' which stands for Response, Action, Prevent, Investigate, Detain and is an acronym to help officers managing DA responses and investigations.

19.27 Under 'INVESTIGATE' is a 'DA Digital Toolkit' which highlights the importance of looking at digital lines of enquiry in DA investigations.

19.28 **Access to MARAC information**

19.29 The IMR author also felt that the force needed to ensure that MARAC actions and outcomes were recorded on Safeguarding Reports so that officers were sighted on the relevant updates. The updates were recorded on a MS Teams page, meaning only a limited group of officers being able to access them. By recording on the Safeguarding Reports, all officers and staff can be sighted.

19.30 Due to his review this has been resolved, and all MARAC actions are added to Safeguarding Reports now by the area Safeguarding Teams who attend MARACs.

19.31 **National Probation Service (Cumbria)**

19.32 Jo was a victim of abuse and controlling behaviour; learning for the service has been identified around the fact that this impacted on her ability to engage with services and seek support.

19.33 Whilst Jo was motivated to engage with services there was no further escalation with other agencies around concerns in relation to her mental health.

19.34 The IMR author therefore recommends refresher training around MARAC and how the Safe Lives DASH risk assessment can be used to inform MARAC referrals. This will up-skill probation staff.

19.35 There has already been steps to improve delivery of alcohol services with Recovery Steps and there was a re-launch of practice guidance and all probation staff briefings. The IMR

author recommends that this be reviewed to ensure implementation of the new guidance in Cumbria.

19.36 A further recommendation made was that if any Person on probation presents with suicidal thoughts, that management oversight is required on this case.

19.37 The probation service does not currently consistently have a specific risk assessment tool for those individuals who are victims of abuse. The OASys assessment focuses on risk posed by individuals however, there is scope to explore risks to the individuals. This includes risk of suicide and self-harm towards the individual. Community Mental Health and Probation have a clear route of referral and there is an escalation process if there are mental health concerns.

19.38 There remains a gap however in the understanding and consistent recognition, assessment and management of risk of domestic abuse posed *to* a person on probation and no victim-focused risk assessment tool is currently used by the service. This impacts on their ability to assess and support individuals where the risk of harm posed to them by a partner, ex-partner or family member is present.

19.39 Currently there is no formal risk assessment for individuals who are the potential victims of domestic abuse. However, the probation service's recognised risk tool, OASys, does allow for it to be recorded that the individual is the victim of domestic abuse, as well as perpetrator. There is also the ability to record relationship issues and vulnerabilities, and this can be reflected in the risk summary and risk management plan.

19.40 Probation Practitioners do have access to the DASH safe lives risk assessment tool as a part of a MARAC referral, but this is not a mandatory risk assessment tool used by all probation practitioners.

19.41 This may have been a factor in the lack of information shared by the probation MARAC representative about Jo's disclosures of abuse, which prevented her accessing the most appropriate service or any targeted and specialist support.

19.42 The IMR author highlighted that all staff are required to undertake statutory e-learning in relation to domestic abuse. Staff are then required to undertake a two-day classroom training specifically in relation to domestic abuse. This training must be renewed every three years.

19.43 The training specifically explores statutory responsibilities, recognising domestic abuse, the impact of domestic abuse and working in a multi-agency forum. This specifically focuses on managing those individuals who have *committed* domestic abuse offences and how as a service we can protect the public, known victims and children. The training is underpinned by the ‘Domestic abuse policy framework’.

19.44 Probation has also implemented the 'Touchpoint model' in relation to management oversight. This means that all probation cases have management oversight, this may be a 'light touch' approach, or more intrusive, dependant on complexity of case and the risk.

19.45 The IMR author explained that Probation Practitioners are aware that any domestic abuse incident/crime should be reported to Police via 101. As part of the induction process for People on Probation, they are informed that if they report any crime then probation practitioners are required to inform the Police, and this is in accordance with Data Protection. This was the practice expectation at the time of Jo's induction and was a part of the induction process and the consent form (Person on Probation Induction Pack V1.0).

19.46 The IMR author highlighted that 'any crime reported to a Probation Practitioner should be reported to Police, and that difficulties arise when the victim doesn't not want us to report but we should still report for future reference / crime investigation'. The Probation risk management approach, following a disclosure of DA, is to encourage the individual to disclose the incident to Police, and if not, the Probation service has a duty to disclose this information under an exemption under the Data Protection Act. The Probation practitioner can also refer to MARAC and request a Police Domestic Violence Disclosure Scheme (DVDS) for any potential victims of domestic abuse.

19.47 Despite this practice expectation, this did not happen in Jo's case. Jo disclosed she was the victim of a crime, contrary to Section 76 of the Serious Crime Act (Coercive and controlling behaviour in an intimate relationship) to her PSO, but this was never reported to the Police, and even at the MARAC that a probation representative attended, they did not share this crucial information in that forum.

19.48 This represents a breach of expected practice within the probation service, but it also draws focus to the wider consideration for this mandatory reporting of any incident/crime to police. This might be understandable if the person on probation is the perpetrator who discloses or admits the offence, but if they are the victim, this is a different matter.

19.49 Either way there are inherent risks to the victim and a nuanced, trauma and DA informed approach must be taken in each case. The panel has concerns around the efficacy of the probation service to adequately recognise, assess and support victims of domestic abuse and a lack of confidence in their understanding of the dynamics of DA from a victim's, rather than a perpetrator's, perspective.

19.50 In relation to self-identified learning, the IMR author identified the need for the following actions to be completed by March 2024;

- the Cumbria Probation Delivery Unit (PDU) to complete refresher training in relation to MARAC referrals.

- a review of the efficacy of the 'Pathways Guidance' between Probation and Recovery Steps in relation to the Alcohol and Drug Treatment requirements which are imposed by the courts. The purpose of this review is to ensure good information sharing and treatment pathways, resulting in positive outcomes for the service user.

- Management oversight in cases of suicide / self-harm and evidence of such case discussions within probation's recording system.

19.51 **Recovery Steps**

19.52 The IMR author felt that had there been more exploration from Recovery Steps regarding Jo's relationship with her Lilith, particularly at the point when Jo described it as being 'volatile', then there may then have been more of a multi-agency response identified as being required and subsequently initiated by Recovery Steps. This is an issue of lack of professional curiosity around relationships and the potential presence of domestic abuse

19.53 Since this case there has been significant development relating to safeguarding practice across Addictions services. Many of these have been prompted by the recommissioning of services to a new care provider and some have been a result of the learning from internal and external incidents and reviews.

19.54 An Integrated Governance Board (IGB) has now been developed across Addictions services to support oversight, review and learning from all incidents across the service. Within the IGB structure, a specialist Safeguarding Practice Subgroup has been set up, which is supporting the development of safeguarding practice and ensuring learning identified from internal and external reviews is embedded within future practice.

19.55 Addictions Services have identified Safeguarding and MARAC Leads within each locality. These leads provide specialist advice and support to staff regarding domestic abuse. Specialist safeguarding supervision is available to all Addictions service staff on a monthly basis, whereby staff can discuss complex safeguarding cases.

19.56 Within the service transfer to Humankind on 01.10.2021, Addictions services have implemented a clinical recording system that has a designated safeguarding function, inclusive of domestic abuse. This is aimed at supporting effective safeguarding oversight and documentation within service users' care records.

19.57 Areas to strengthen for the service is the implementation of targeted training in relation to domestic abuse and standardising the use of the CAADA-DASH Risk Identification Checklist.

19.58 Domestic Abuse is to be added as a specific agenda item for Safeguarding Supervision.

19.59 **Temple Sowerby (GP1)**

19.60 Routine /selective enquiry about DA has been recognised as an area for improvement across GP practices in North Cumbria. The Integrated Care Board (ICB) has recently helped to develop a pop up on the electronic record to prompt consideration of DA enquiry if certain clinical codes are added e.g. 'depression' or 'substance abuse'. This was made available to GP practices early in 2023. There is also a template that is available to help the clinician record that they have asked the question and the outcome of the discussion e.g. referral to victim support if there is a disclosure of abuse.

19.61 The practice will ensure that this is adopted and the ICB will be monitoring how often this is being used by practices going forward.

19.62 Multiagency learning identified by the practice from Jo's experience is the importance of GP practices being notified if any of their patients are victims of domestic abuse. The ICB have been working with police in Cumbria to ensure that GP practices are informed if any of their patients are being discussed at MARAC meetings. There are plans in place to systemise this approach and use wider learning of approaches taken across NENC ICB to support. It is hoped that this process will be in place soon.

19.63 There are eight (8) Integrated Care Communities (ICCs) across North Cumbria, and these are coterminous with the Primary Care Networks (PCNs). A Mental health Multi-disciplinary Meeting (MDT) was piloted in Copeland ICC and there is a plan to roll these out across all ICCs. Agencies involved include CNTW, primary care, Police, third sector and Recovery Steps. Eden and Carlisle ICCs do not currently have these MDT meetings, but Jo's case would have benefitted from a multiagency discussion.

19.64 In relation to self-identified learning, the IMR author recognised the need for the following actions to be completed;

- Increase routine enquiry around domestic abuse in primary care consultations.
- Implement information sharing between MARAC team and GP practices .

19.65 **Eden Medical Practice (GP2)**

19.66 Jo did not attend her planned appointment with Unity on 06.07.2021. Unity sent a letter informing the Practice of this, but the letter was filed by the scanning team and without being seen by a clinician. A clinician would only see the letter if they went on and read the patient notes.

19.67 This means that no follow-up call would be made, or action taken as the GP would not be alerted to such information. This represents a missed opportunity to reach out to patients and enquire about their reasons for not attending and see if there were any needs or risks which needed addressing. This was especially important in Jo's case as she was vulnerable to ongoing mental health crises and problematic alcohol use requiring the prescription of Thiamine.

19.68 The Practice have since introduced a system whereby all missed appointment letters for both children and adults are flagged with the registered GP and/or the Safeguarding team. The Safeguarding Administrator would then review the records and check with the Wellbeing and Safeguarding Lead to the patient's registered GP regarding follow up/action required.

19.69 The W&S lead has now been in post for 1 year, with the Safeguarding Administrator (SA) being present for almost the same amount of time. At the start of the roles, the main priority was reviewing safeguarding registers for children and reinstating the regular health visiting/strengthening families review meetings. There was also some reassurance that the Frailty team were having weekly MDT meetings with Social care.

People like Jo, functioning adults but with vulnerabilities and who had services involved, were sadly not priority as it was felt they were having relevant input. Now that there are established meetings for children and young people, the W&S lead along with the SA have regular meetings to discuss any current concerns and the team feedback to relevant clinicians, or seek clarification from clinicians if they are due to see the person of concern i.e. they are asked to feedback if miss appointment, if issue with presentation etc.

19.70 With regards to a patient attending for suture removal, the practice W&S Lead feels confident that if such a presentation were to happen today, it would be questioned, and that the clinician would use professional curiosity to ask for an explanation. My confidence on challenging such a presentation now on suture removal is due in part to the practice having a stable Wellbeing and Safeguarding team who are accessible and proactive in sharing information and support.

19.71 The practice have had teaching sessions, both informally, such as “clinical huddles” (a 15 minute middle of the day gathering for available clinicians to discuss any concerns or share relevant information) or formally through Protected Learning Time sessions.

19.72 The W&S lead also disseminates emails to colleagues relating to any relevant Safeguarding information and will present the findings of this, and other Reviews to the whole team.

19.73 The W&S lead is now also regularly getting sent reports from colleagues regarding presentations including a burn in a middle aged diabetic whereby 'non accidental injury was considered; a male showing photos of an alleged rash but images appearing to be from a younger individual rather than himself; a child who was dirty. This is just three examples of where this has happened and is felt this is because there is now a dedicated team for Wellbeing and Safeguarding who are very visible within the practice.

19.74 With regards to Jo’s missed attendance with Unity, the practice now flag missed appointments, not just for children but for adults deemed vulnerable also. This has been an opportunity to share with the team, and more of these documents highlighting missed appointments are now rerouted through to the Safeguarding Administrator.

19.75 In hindsight, looking at the past information (appears this was the second time in less than a year whereby alcohol was involved, as per Liaison and Diversion team report), and the lack of some information, more professional curiosity might have built a fuller picture of Jo and had we not still be living in a “COVID world”, we may have had more opportunity to call Jo in for a formal review and been better able to assess her mental state and wellbeing.

19.76 We may then have been able to confidently and safely question Jo regarding potential domestic abuse; most consultations for Jo were via the telephone and clinicians cannot tell if anyone else is present at the other end of the line.

19.77 At the time of Jo’s registration and subsequent tragic death, there was no routine questioning in the practice regarding Domestic Abuse. This was subsequently started routinely in family planning consultations, when women often attend alone for coil and

implant fits. The practice has now enabled the Domestic Abuse (DA) template supplied to general practice and has the pop up alert to remind clinicians to think about DA as a possibility when patients present with mental health difficulties etc.

19.78 In relation to self-identified learning, the IMR author recognised the need for the following actions to be completed;

- Raising awareness regarding alcohol use and Domestic Abuse in general and introduce the role of a new DA champion within the practice

19.79 **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)**

19.80 In Crisis Team contact in September 2020, Jo was encouraged to 'self-refer' to Unity (now Recovery Steps) however the IMR author considers that a referral should have been completed on Jo's behalf to encourage engagement with the service and share information. This has been identified as an area of learning for the team.

19.81 The review noted that clinicians recognised Jo's treatment needs including psychological intervention to address her mood dysregulation, anxiety and depression and that her intermittent alcohol use would have a negative impact on her mental and physical health. Clinicians noted that her ability to engage with mental health services consistently presented challenges for her and directing her to self-refer to Unity was not helpful. Expected practice would be to ensure that a referral was completed with Jo ’s consent to alert Unity and GP services to promote psychosocial intervention to reduce her alcohol use.

20 RECOMMENDATIONS

20.1 **This section of the report details the focused, specific, and capable of being implemented Recommendations made in individual management reports and includes recommendations of national impact made for national level bodies or organisations.**

20.2 **The overall conclusions reached by this review (Section 18) have also influenced these recommendations in relation to areas where practice needs to be improved, there are;**

- Lack of professional curiosity.
- Lack of awareness and application of the 'typologies of abuse' and differentiation of types of abuse and abuser.
- Lack of adequate inter-agency information sharing, e.g. within the MARAC setting.
- Lack of clarity around service and support pathway primacy for individuals with dual diagnosis (mental health and addiction issues).
- Bias/unconscious bias around intoxicated witnesses.
- Lack of adequate victim focused risk assessment usage where domestic abuse is disclosed or suspected.

20.3 **Cumbria Constabulary**

20.4 **Recommendation 1**: Addition of trauma-informed approaches in domestic abuse training and for officers to understand why people are behaving in such a way when we encounter them. E.g. are they using alcohol to mask emotions related to a past event.

20.5 **Recommendation 2:** The force should implement Trauma-Informed practice awareness training, embedding in policy and practice.

20.2.1 **Temple Sowerby GP practice & Eden GP Medical Practice (North East North Cumbria Integrated Care Board)**

20.2.2 **Recommendation 1:** Promotion and embedding of routine enquiry around domestic abuse in primary care to increase the number of times patients accessing primary care are asked 'How safe do you feel?'

20.2.3 **Recommendation 2:** Explore training and practice support options for a new DA champion role within the practice. Goal is for every practice in North Cumbria to have a domestic abuse champion.

20.2.4 **Recommendation 3:** Training and information resources for primary care will include learning and recommendations from this DHR and health pathways with relevance to this case will reflect learning from this DHR.

20.2.5 **Probation Service Cumbria**

20.2.6 **Recommendation 1:** Cumbria Probation Delivery Unity to complete refresh training in relation to MARAC referrals.

20.2.7 **Recommendation 2:** Probation and alcohol services ensure the effective delivery of alcohol treatment requirements.

20.2.8 **Recommendation 3:** Probation Practitioners to seek management oversight when a person on probation presents with suicidal/ self-harm behaviour.

20.2.9 **Recommendation 4:** Cumbria Probation Delivery Unit to revisit guidance issued in 2024 in relation to domestic abuse disclosure (including DVDS).

APPENDIX 1

GLOSSARY

CCG	Clinical Commissioning Group
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DARDR	Domestic Abuse Related Death Review
GP	General Practitioner
ICC	Integrated Care Communities
IMR	Individual Management Report
ISVA/IDVA	Independent Sexual Violence Advisor / Domestic Violence
SCIE	The Social Care Institute for Excellence
TOR / ToR	Terms of Reference
SAF	Safeguarding Adult Form
VA	Vulnerable Adult
APP	Approved Professional Practice (College of Policing Guidance)
ASC	Adult Social Care
DA	Domestic Abuse
DASH (RIC)	Domestic Abuse, Stalking, Harassment and Honour Based Abuse (Risk Indicator Checklist)
MARAC	Multi- Agency Risk Assessment Conference
MDT	Multi-Disciplinary Team
CCHA	Castles & Coasts Housing Association
CCC	Carlisle City Council
SIO	Senior Investigating Officer
SPA	Single Point of Access
L&D	Liaison & Diversion
SAB	Safeguarding Adults Board
PPU	Public Protection Unit
NPS	National Probation Service
PSO	Probation Service Officer
PCN	Primary Care Network

APPENDIX 2

Domestic Abuse Related Death Review Terms of Reference

Aims and Purpose

The aim of a domestic homicide review (DHR) is to:

a. "Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c. Apply these lessons to service responses including changes to the 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 coordinated 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" (*Multi-agency statutory guidance in the conduct of domestic homicide reviews,* Home Office, 2016)

Panel Membership

Bridie Anderson has been appointed as the Independent Chair and Author for this review. The panel is to include representatives from the following agencies:

- Recovery Steps Cumbria
- Cumbria Constabulary
- Carlisle City Council
- Carlisle National Probation Service
- Cumbria, Northumberland Tyne and Wear NHS Trust
- North Cumbria Clinical Commissioning Group
- North East and North Cumbria Integrated Care Board
- North Cumbria Community Safety Partnership (Co-ordinator)
- Victim Support
- North West Ambulance Service

Panel representatives will normally have had no direct involvement in the case and will not have been direct line managers of those who provided services.

Timeframe

The Review Panel will consider each agency's involvement with the individual's listed below from 1st August 2019 until 21st February 2022, as well as all contact prior to that period which may be relevant to safeguarding, domestic abuse, violence, controlling or coercive behaviour, self-harm, mental health issues or substance abuse.

- Victim: Jo, who was 28 years of age at date of her death
- Suspect: Lilith

The Domestic Homicide Review will identify agencies that had, or should have had, contact with Jo and/or her partner Lilith between **1st August 2019**, when Jo moved back to the Cumbria area from Leeds, and the date of her death recorded as **21st February 20022.**

The review will also consider relevant information relating to agencies' contact with the victim and her partner outside that time frame if it impacts on agency involvement in this case.

Agencies that have had contact with Jo and/or Lilith should:

- Secure all relevant documentation relating to those contacts.
- Produce detailed chronologies of all referrals and contacts
- Commission an Individual Management Review (IMR) in accordance with respective Statutory Guidance for the Conduct of Domestic Homicide Reviews.

Affected Agencies

The following agencies who have had significant contact are asked to contribute a proportionate IMR and chronology to the review:

- Recovery Steps Cumbria
- Cumbria Constabulary
- Carlisle City Council
- Carlisle National Probation Service
- Cumbria, Northumberland Tyne and Wear NHS Trust
- Primary Care
- North Cumbria Clinical Commissioning Group
- North Cumbria Integrated Care NHS Foundation Trust
- Victim Support

Equality and Diversity

The review will consider all protected characteristics, as defined by the Equality Act 2010, including age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. The review will consider any additional vulnerabilities relevant to the individuals concerned. At the outset, issues of sex and gendered violence, mental health, sexual orientation and substance misuse have been identified as particularly pertinent to this review.

Key Lines of Enquiry

The review should address both the 'generic issues' set out in the Statutory Guidance, in Appendix 1 below, and the following specific issues identified in this particular case.

Individual Management Review Authors will be asked to respond to the following questions, where relevant, in respect of their involvement in key episodes with the individuals involved during the period specified above.

1. **Individual Practice: how effective were agencies in identifying and responding to the needs and risks faced by the victim?**

Reflective Questions. In response, can you consider:

- *A pen picture of how the individuals were known to you.*
- *What knowledge your agency had about the relationship between the victim and the alleged perpetrator?*
- *What needs did your agency identify for either individual and how did your agency respond?*
- *What specific support was made available to the victim as a result of her repeat domestic abuse involvement?*
- *What opportunities were there to engage and refer over mental health issues and how was mental health considered/responded to in the context of domestic abuse?*
- *What opportunities were there to engage and refer over substance misuse issues and how was substance misuse considered/responded to in the context of domestic abuse?*
- *How were decisions made, and actions taken by agencies to reduce risk and prevent harm, considering, for example:*
  - *indicators of risk; how risk was assessed and managed; attention to previous history; identifying pre-existing vulnerabilities; how were the individual's attitudes to risk perceived and understood, and how did this affect decisions made or actions taken;*
  - *How substance misuse impacted upon assessment and response to risk?*
  - *Safety planning; escalation; managing risk on closure of cases?*
  - *What actions were taken to respond to and manage the alleged domestic abuse and how effective were they in harm reduction?*
- *If domestic abuse was not known about, how might your agency have identified the existence of domestic abuse from other issues presented to you? For example, were there policies and procedures for direct or routine questioning and how well were they implemented in this case?*
- *What barriers to engagement did agencies face and how did they seek to overcome these barriers?*
- *How did agencies recognise and respond to issues of equality and diversity for either individual?*
- *Was there any evidence of unconscious bias in the assessments, decisions or services delivered?*

- *How effective was record keeping?*
- *How effective was management oversight?*
- *Did resource issues impact upon services offered?*
- *How the Covid-19 pandemic impacted upon agencies' responses?*

2. **Multi-Agency Practice: how effective were agencies in working together to prevent harm and to meet individuals' needs?**

   Reflective Questions. In response, can you consider:

   - *How were roles and responsibilities understood, and multi-agency protocols adhered to?*
   - *Was there a shared ownership and approach?*
   - *How effective was the co-ordination of services?*
   - *How effective was communication, information sharing and sharing records?*
   - *How effective was escalation between agencies?*

3. **Can you identify areas of good practice in this case?**

4. **Improving services:**

   - *What lessons can be learnt to prevent harm in the future?*
   - *What recommendations are you making for your organisation and how will the changes be achieved?*
   - *What system-wide, multi-agency recommendations do you consider need to be made?*

The review may adopt further lines of enquiry as further information becomes available. A briefing for IMR authors will be provided by the Independent Chair if required.

Engagement with those directly affected

The review will sensitively attempt to engage with family members, in keeping with the Statutory Guidance which states that, *"Their contributions, whenever given in the review journey, must be afforded the same status as other contributions"* (Home Office, 2016). The Independent Chair will be responsible for this engagement with the support of the Community Safety Partnership Co-ordinator.

The Panel will identify which family members, friends, neighbours, work colleagues and informal networks should be invited to participate in the review, subject to any ongoing police investigations.

Practitioners who were directly involved in the case should, wherever possible, have the opportunity to directly contribute to the review. The panel will consider the means by which this is facilitated.

Specialist and Legal Advice

The review may seek specialist and legal advice as deemed necessary by the panel.

Parallel proceedings

- The coroner's inquest into Jo's death was due to take place in August 2022. The inquest has been adjourned pending the outcome of the police investigation and the Domestic Homicide Review.
- The independent Chair will keep the coroner's office updated as to the progress of the Domestic Homicide Review in order that the inquest can be commenced without any unnecessary delays.

Confidentiality

All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative and the Chair.

All agency representatives are personally responsible for the safe transfer and safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

Media Handling and Publication

No information will be made public until the end of the DHR process and when the report has been authorised for publication by the Home Office. All media enquiries should be directed to the Community Safety Partnership who is responsible for the final publication of the report and for feedback to family members and the media. Affected agencies are responsible for providing timely feedback to staff that have been involved throughout the process of the review.