



**WOKINGHAM**  
**BOROUGH COUNCIL**



Domestic Homicide Review

# Executive Summary of the Domestic Homicide of Jessica in September 2022

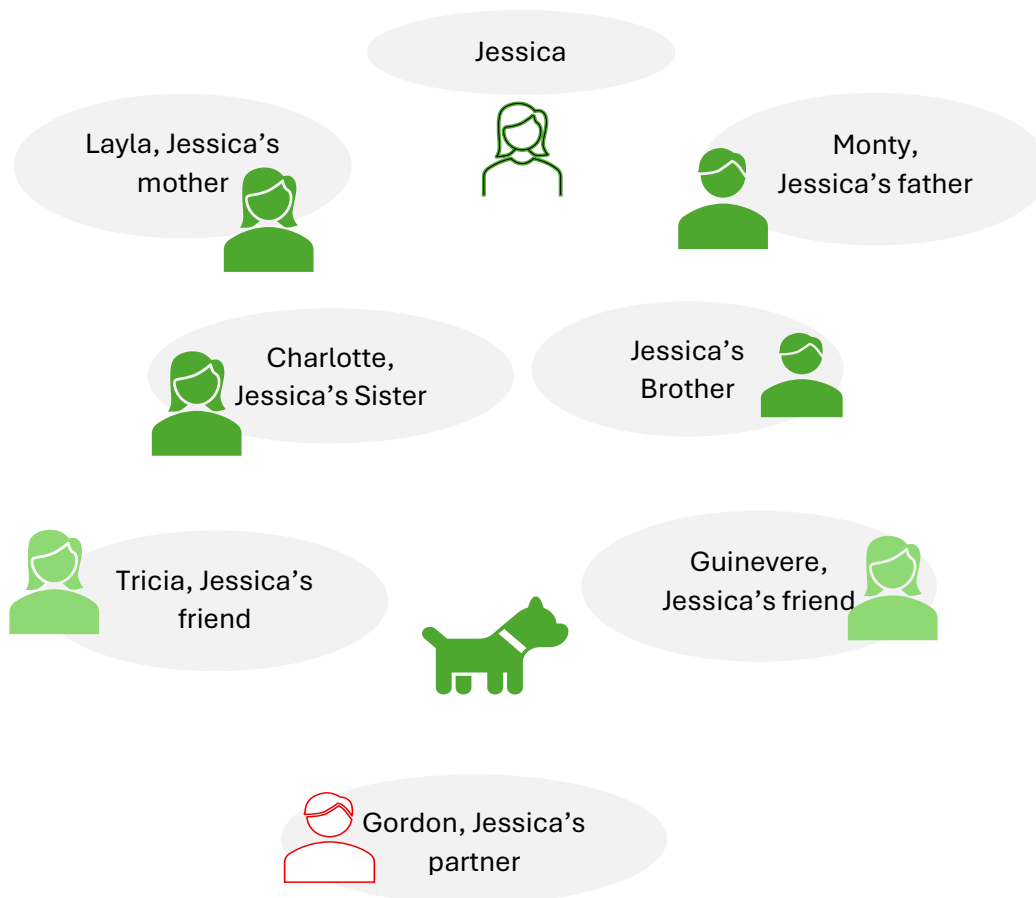
**Parminder Sahota Independent Chair and Author**  
PS SAFEGUARDING LTD JUNE 2025

## Preface

The independent reviewer and review panel extend their heartfelt condolences to all those affected by Jessica's tragic and sudden death. They also thank everyone who contributed to and supported this critical review process.

Pseudonyms chosen by the family have been used throughout the review to protect the identities of those involved. The only individuals identified by name are the independent reviewer and the review panel members.

### **Jessica's family, friends, her beloved dog and partner:**



The primary aim of a Domestic Homicide Review (DHR) is to learn from the circumstances surrounding the death of an individual where domestic abuse was known or suspected. Professionals must engage with the unique context of each case to ensure that the lessons identified are meaningful and actionable. Through this understanding, we can work towards implementing changes that help prevent future deaths related to domestic abuse.

The reviewer thanks the panel members and all those who provided chronologies and supporting documentation for their time, commitment, and cooperation.

Special thanks are also extended to Jessica's family and friends, whose insights and contributions were invaluable in shaping a review that genuinely reflects Jessica's life and story.

*Jessica was compassionate, fun-loving, bright, and had a grand sense of adventure. She will be missed.*

*Family*

*Jessica was an independent, bright, brilliant woman, whose light will always burn bright, especially on Eurovision night.*

*Friend*

*Jessica was always razor-sharp, always funny, sometimes bonkers, and always memorable. Rest in peace, my friend. I shall miss your late-night texts. Love always.*

*Friend*

*Jessica was loyal, trustworthy, kind, loving, easygoing, caring, and dependable. I didn't do her justice by saying she was intelligent and a great friend.*

*Guinevere*

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## Section One: The Review Process

- 1.1.1 This summary outlines the process undertaken by the Wokingham Community Safety Partnership (CSP) in reviewing the death of Jessica, who was a resident in the area.
- 1.1.2 Jessica died at the age of forty-three, leaving behind her beloved small dog, her parents, and two siblings. She had a successful career as a journalist, published author, and freelance writer, supporting herself and her partner, Gordon, who was unemployed.
- 1.1.3 Jessica was known for her intelligence, curiosity, and adventurous spirit. She had a deep love for reading, travelling, and socialising. Her friends and colleagues remember her fondly for her warmth, wit, and generosity. Despite her often disorganised nature, she was cherished for her kindness and fun-loving personality.
- 1.1.4 Her family and loved ones deeply mourn her loss and remember her as a compassionate daughter, sister, and friend who impacted those around her.
- 1.1.5 The Domestic Homicide Review (DHR) process commenced with the CSP in April 2023, and a decision was made to hold a DHR in June 2023. All agencies that potentially had contact with Jessica and Gordon before her death were contacted and asked to confirm whether they had been involved with them.
- 1.1.6 Seven agencies confirmed contact and were asked to secure their files.
- 1.1.7 The review assessed agency responses, support mechanisms, and systemic barriers that may have influenced Jessica's ability to access safeguarding and support.
- 1.1.8 The review period covered **March 2020 to September 2022**. In March 2020, Jessica contacted Thames Valley Police (TVP) and disclosed that Gordon had attempted to strangle her, and in response, she assaulted him. This led to the initial interaction with TVP concerning a domestic abuse incident and Gordon's arrest.
- 1.1.9 Jessica and Gordon lived together in Wokingham, and they regularly consumed alcohol beyond NHS guidelines. In 2020, Jessica sought support from SMARTCJS, an alcohol service.
- 1.1.10 Between 2020 and 2022, TVP responded to ten domestic abuse reports, with both Jessica and Gordon identified as victims or perpetrators at different times. However, they consistently declined support from domestic abuse services and did not engage in police investigations, resulting in no further action being taken.
- 1.1.11 In December 2021, Jessica was admitted to the Royal Berkshire NHS Foundation Trust (RBH) due to seizures. She revealed that Gordon was shouting at her and drinking

heavily. RBH doctor recognised this as domestic abuse and offered her information for Berkshire Women's Aid, but Jessica declined the offer, and no further responses were documented.

- 1.1.12 In August 2022, emergency services were called by Jessica's family. Jessica was found immobile on the sofa with significant pressure sores, surrounded by empty wine bottles. She had been in this state for at least three days, and Gordon had not sought medical assistance. The paramedics raised concerns with Adult Social Care (ASC), and Jessica was transported to the Royal Berkshire NHS Foundation Trust (RBH).
- 1.1.13 Jessica died twenty-three days later. A post-mortem determined her cause of death as multiple organ failure due to alcoholic liver disease.
- 1.1.14 TVP investigated Jessica's death, starting in August 2022, focusing on two offences: ill-treatment or neglect under the Mental Capacity Act (2005), and causing or allowing death or serious harm to a vulnerable individual under the Domestic Violence, Crime and Victims Act (2004).
- 1.1.15 An Officer in the Case from the TVP, West Berkshire Domestic Abuse Investigation Unit, led a thorough investigation spanning nearly three years. This included interviewing Gordon, conducting house-to-house enquiries, reviewing witness statements, examining electronic devices, and analysing diary entries. Contacts with the couple were also approached.
- 1.1.16 After a comprehensive review, TVP concluded that the evidence did not meet the threshold for charges. This decision was communicated to the family, who raised valid concerns that were investigated. However, the same conclusion was reached by April 2025. TVP expressed their deepest sympathies to the family.
- 1.1.17 Jessica's family engaged with an advocate from Advocacy After Fatal Domestic Abuse (AAFDA), who facilitated communication with the independent reviewer. In October 2023, Jessica's parents, Layla and Monty, her sister, Charlotte, and the advocate met the reviewer virtually. The family provided a photograph and tribute to Jessica, which was shared with the review panel.
- 1.1.18 Jessica moved to Wokingham in 2019, selling her home and using the proceeds to pay Gordon's mortgage. At her family's urging, she consulted a solicitor and became the owner of two-thirds of the property. The family reported that Gordon had proposed marriage. They also stated that Jessica lost work contracts due to Gordon disrupting her virtual interviews.
- 1.1.19 Jessica had consumed alcohol for many years but did not consider it a problem. She told her family she had stopped drinking a year before her death. However, after her death, they learned she had sought alcohol treatment for both Gordon and herself.

- 1.1.20 They believed the COVID-19 lockdowns significantly impacted her well-being, limiting her travel and her ability to visit family and friends.
- 1.1.21 Jessica was diagnosed with epilepsy in 2021, and her medical consultations were conducted remotely. In spring/summer 2022, she informed her epilepsy nurse that she was not eating and had lost weight, but without in-person appointments, the extent of her health decline went unnoticed.
- 1.1.22 In August 2022, concerned about her lack of contact, her family visited Jessica and found her in severe self-neglect and her mobile phone was hidden. They called an ambulance, and she was admitted to RBH. The family had agreed on a password with the hospital to restrict visits, but they were distressed to learn that Gordon was still allowed to see her. The hospital clarified that passwords were primarily used for information-sharing rather than visit restrictions unless a specific risk was identified.
- 1.1.23 The reviewer spoke with two of Jessica's close friends. Tricia, Jessica's best friend of twenty years, last saw her in 2021 and later spoke with her in June 2022. Despite multiple attempts to reach her, Jessica stopped responding. Tricia had disliked Gordon and suspected financial abuse but did not perceive Jessica as being at risk of domestic abuse. Jessica had mentioned her epilepsy diagnosis and her decision to stop travelling alone.
- 1.1.24 Guinevere, another close friend, was aware of Gordon's heavy drinking and aggressive behaviour towards others. While she had never seen him physically harm Jessica, she had overheard verbal abuse. Jessica would dismiss concerns and defend Gordon. Guinevere noted that Jessica sounded weak during their last conversation in June 2022. Jessica later texted her, apologising for Gordon's behaviour and attributing it to his alcohol use and depression
- 1.1.25 In May 2025, the report was shared with Jessica's family and the advocate. They highlighted some factual inaccuracies, and no further amendments were required.
- 1.1.26 Following their review of the draft report, Jessica's family requested a meeting with the review panel, which was held on 7 July 2025, chaired by Parminder and supported by their AAFDA advocate. Condolences were extended on behalf of all agencies.
- 1.1.27 The family raised concerns about:
- **Police conduct**, including poor communication and being told by their MP that media involvement was necessary for progress. The police panel member acknowledged these concerns and committed to following up with the family outside of the meeting.

- **Hospital decisions**, specifically disagreement with the assessment that Jessica consented to contact Gordon.
- **Use of telemedicine**, which the family felt contributed to missed opportunities to recognise Jessica’s deteriorating health.
- **Sharing of learning**, seeking clarity on how findings would be disseminated.

1.1.28 In response, panel members outlined how learning from the review would be shared within their respective organisations, and reflected on the impact of hearing directly from the family in shaping professional practice,

1.1.29 The panel confirmed the following steps, including finalisation of the report, submission to the Home Office, and continued communication with the family. The CSP has established a contact point to keep the family informed about progress against the action plan.

1.1.30 The panel thanked the family for their valuable input, which ensured Jessica’s voice remained central to the review and supported meaningful learning across agencies.

## Section Two: Contributors to the Review

2.1.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution- Chronology/IMR/Summary/Other
<b>Adult Social Care (ASC)</b> Wokingham Borough Council ASC assists individuals aged 18 and over in the Wokingham area who need support due to illness, disability, or frailty, offering both short- and long-term help.	Chronology and Summary
<b>Berkshire Healthcare NHS Foundation Trust (BHFT)</b> A community and mental health trust offering a comprehensive range of services to people of all ages residing in Berkshire.	Chronology
<b>GP Practice</b> , represented by Buckinghamshire, Oxfordshire & West Berkshire Integrated Care Board (ICB)	Chronology and Summary
<b>Royal Berkshire NHS Foundation Trust (RBH)</b> General Hospital	Chronology and Summary
<b>SMARTCJS</b> Alcohol and Drug Service	Chronology
<b>South Central Ambulance Service NHS Foundation Trust (SCAS)</b>	Chronology

2.1.2 The responses were written by professionals not involved in case management or service delivery.

### Section Three: The Review Panel Members

3.1.1 The independent panel members for this review were the following:

Name	Role	Organisation
Elizabeth Porter	Lead Nurse Adult Safeguarding	Royal Berkshire NHS Foundation Trust
Jaqueline Osborne	Adult Safeguarding Practitioner	South Central Ambulance Service NHS Foundation Trust
Jen Robus (withdrew August 2024)	Chief Executive Officer	SMARTCJS
Katie Lloyd	Head of Service (Domestic Abuse)	Cranstoun
Karen Evans	Domestic Abuse Coordinator	Wokingham Borough Council
Karen Glaister	Interim Head of Adult Safeguarding and Care Governance	Wokingham Borough Council
Kathy Kelly	Designated Head of Safeguarding Adults	Buckinghamshire, Oxfordshire & West Berkshire Integrated Care Board (ICB)
Narinder Brar	Head of Enforcement and Safety	Wokingham Borough Council
Rebecca Berry	Adult Safeguarding, Quality and Development Manager	Wokingham Borough Council
Rowena Perry	Business Support Officer	Wokingham Borough Council
Richard Jarvis	Detective Chief Inspector	Thames Valley Police
Shirley Scotcher (joined March 2025 and left June 2025)	Chief Executive Officer	SMARTCJS
Vikki Lake	Head of Service (Drugs and Alcohol)	Cranstoun

3.1.2 SMARTCJS no longer maintains a presence in Wokingham. The panel member supported the panel to investigate the vulnerabilities of women who are experiencing multiple vulnerabilities, an increased risk of domestic abuse, and responses from agencies.

3.1.3 The panel met a total of ten times, including one meeting with Jessica's family.

## Section Four: Chair and Author of the Overview Report

- 4.1.1 Parminder Sahota was appointed the Independent Chair and Author for this review. She is a highly experienced safeguarding and domestic abuse professional with over 20 years of experience in the NHS, specialising in mental health, crisis intervention, and support for individuals with complex needs.
- 4.1.2 Parminder has held senior safeguarding roles, including Director of Safeguarding and Domestic Abuse Lead, and is a qualified Best Interests Assessor. She brings a strong understanding of multi-agency work, safeguarding frameworks, and risk management.
- 4.1.3 She has completed AAFDA-accredited DHR Chair training (2021, 2024) and previously chaired a DHR for the Wokingham CSP. Parminder is independent of all agencies involved in this review and had no prior contact with Jessica's family or friends.
- 4.1.4 Her trauma-informed and culturally competent approach supports sensitive stakeholder engagement, critical analysis, and the development of evidence-based recommendations to drive meaningful learning and improvement.

## Section Five: Terms of Reference

- 5.1.1 The statutory guidance sets out the purpose of DHRs:
  - a. Establish what lessons are to be learned from domestic abuse-related death regarding how local professionals and organisations work individually and together to safeguard victims.
  - b. Identify the lessons within and between agencies, how they will act on them, within what timescales, and the expected changes.
  - c. Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.
  - d. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a 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.
  - f. Highlight good practice.
- 5.1.2 The review intends to identify the lessons learned from Jessica's death and respond to those lessons to prevent deaths connected to domestic abuse and ensure that individuals and families are supported effectively.
- 5.1.3 The family and panel agreed on fifteen terms of reference (ToR):

1. Identify good practices where responses may have surpassed the requirements necessary.
2. Were Jessica's service responses affected by the COVID-19 pandemic (review appropriate contact/response with current impact)?
3. How readily was Jessica able to use the services?
4. How did your agency respond to the information that Jessica may have been a victim of domestic abuse?
5. Did any agencies that had contact with the alleged perpetrator consider that he may have been a perpetrator of domestic abuse?
6. During Jessica's engagement with your agency, did your agency have any alternatives for perpetrator disruption or victim safety planning? If not, what hurdles prevented their implementation?
7. Does your agency have procedures and policies for identifying and addressing domestic abuse? Have you considered whether these assessment tools, processes, and policies are adequate?
8. During the period covered by this review, was information promptly communicated to all relevant parties?
9. Were collaborative discussions undertaken to review risk factors, including alcohol, domestic violence, and others?
10. What were this situation's most significant considerations and decision-making opportunities? For example, are reviews and decisions based on professional expertise, evidence and knowledge held by organisational and multi-agency policies and procedures?
11. Was there anything else that might have been done, and if so, would it have made a difference?
12. Capability and resources: Were there challenges with your agency's capacity or resources that hindered your ability to deliver services to Jessica, the alleged perpetrator, or other pertinent individuals? In that case, did these concerns hamper the agency's collaboration with other agencies?
13. Are there lessons to be learnt from the case regarding how your agency preserves and promotes the welfare of victims or how it finds, reviews, and manages the risks posed by perpetrators? Where could the method be improved? When interacting with other agencies and resources, are there repercussions for working practices, training, management, and supervision?
14. Can agencies identify areas where national or local enhancements to the present legal and policy framework could be made?
15. Any equality and diversity concerns that appear relevant to the victim and alleged offenders, such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and motherhood, race, religion and belief, sex and sexual orientation, should be addressed in the reports.

## Section Six: Summary Chronology

**March 2020**

- 6.1.1 Jessica reported to TVP that Gordon had strangled her the previous night. When officers attended, both were intoxicated, and Jessica disclosed that while Gordon strangled her, she also assaulted him. Officers recorded that they were "both as bad as each other" and noted that Gordon had not prevented her from breathing.
- 6.1.2 This characterisation of mutual violence may have obscured potential coercive control, a pattern often hidden in domestic abuse cases. Safe Lives has highlighted that coercive control can cause victims to regulate their behaviour, shifting blame away from the perpetrator.<sup>1</sup>
- 6.1.3 Jessica stated she had called the police to discuss leaving the property, but did not report the incident at the time of the assault because she had nowhere to go. This suggests potential barriers to escaping abuse.
- 6.1.4 Officers conducted a Domestic Abuse, Stalking, Harassment, and Honour-Based Violence (DASH) risk assessment,<sup>2</sup> which noted:
1. Physical violence: Jessica reported being grabbed by the throat and retaliating.
  2. Strangulation: Jessica stated she did not feel like she could breathe.
  3. Isolation: Jessica felt cut off from family and friends due to distance rather than Gordon's actions.
  4. Suicide risk: Jessica denied having thoughts of self-harm, but Gordon had expressed suicidal thoughts.
- 6.1.5 The case was graded as 'medium risk,' meaning serious harm was possible under changing circumstances such as relationship breakdown, substance misuse, or loss of accommodation. The review notes that COVID-19 isolation exacerbated tensions, and excessive alcohol consumption was a risk factor.<sup>3</sup>
- 6.1.6 Strangulation is a significant indicator of serious harm, and the Sentencing Council has emphasised its dangers even when there are no visible injuries.<sup>4</sup> This suggests that a referral to the Multi-Agency Risk Assessment Conference (MARAC)<sup>5</sup> should have been considered when assessing Jessica's safety.
- 6.1.7 Gordon was arrested and claimed he grabbed Jessica's neck in self-defence. Following an evidential review, the case was closed with "no further action" due to insufficient evidence from body-worn video, the 999 call, and police notes. A referral was made to the TVP Multi-Agency Safeguarding Hub (MASH), but no further action was taken.

## April 2020

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<sup>1</sup> <https://safelives.org.uk/about-domestic-abuse/what-is-domestic-abuse/coercive-control/>

<sup>2</sup> <https://safelives.org.uk/resources-library/dash-risk-checklist/>

<sup>3</sup> [https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow\\_Pandemic\\_Report\\_FINAL.pdf](https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_Pandemic_Report_FINAL.pdf)

<sup>4</sup> <https://www.sentencingcouncil.org.uk/html-publication/item/strangulation-and-suffocation-offences-guideline-response-to-consultation/>

<sup>5</sup> <https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf>

- 6.1.8 A neighbour reported an argument between Jessica and Gordon, hearing Jessica say, "Ow" and "Get away from me." Jessica later attributed this to her puppy. Both Jessica and Gordon insisted it was only an argument. A house-to-house inquiry found no further evidence, and Jessica declined to complete a DASH assessment.
- 6.1.9 Police action was limited without physical evidence or witness corroboration. The previous DASH assessment, graded as medium risk, was referenced. Officers provided safety advice, and MASH was tasked with safety planning, which Jessica declined to accept following a call from Berkshire Women's Aid in May 2020.
- 6.1.10 The independent reviewer noted that victims' reluctance to engage may indicate coercion or fear. The absence of a new DASH may have underestimated escalation risks, underscoring the need for agencies to investigate the reasons behind disengagement.

#### **June 2020**

- 6.1.11 TVP completed two medium-risk safety planning logs, and a log documenting Gordon's lack of engagement was also completed.

#### **October 2020**

- 6.1.12 Report to TVP from a neighbour of a possible domestic incident in progress. The neighbour was spoken to and advised that the shouting had been going on all day. They thought Jessica had recently lost her job. This aligns with prior incidents where external pressures (e.g., COVID-19 isolation) contributed to domestic conflicts.
- 6.1.13 Jessica opened the door and requested to speak to officers outside the property. She was intoxicated. Alcohol use is a risk factor for domestic abuse.
- 6.1.14 Jessica said they had been arguing about Gordon's friends all day. Officers stated there appeared to be alcohol and mental health issues for both parties. Officers asked Gordon to come to the door. On doing so, they noted that he had a recent swollen black eye. Both parties were evasive about how the eye injury happened.
- 6.1.15 Jessica was arrested for Actual Bodily Harm, and Gordon declined to provide a statement. Body Worn Video (BWV) of attendance and arrest. Jessica declined to participate in the DASH risk assessment, and officers completed it based on the information gathered; they graded the incident as medium risk.
- 6.1.16 Gordon declined to allow photographs of his injuries (but they were visible on the BWV). House-to-house enquiries were completed, and a statement was obtained from the reporting party.
- 6.1.17 Officers re-engaged with Gordon, but he still declined to provide a statement, saying nothing had happened and that he was concerned about Jessica. Jessica provided a no-comment interview and was bailed with conditions for further enquiries.

6.1.18 Gordon was contacted again seven days later and confirmed that he still did not wish to support the investigation. An evidence-led prosecution<sup>6</sup> was considered but precluded due to insufficient supporting evidence. Both parties were informed of the decision to take no further action, and the report was filed.

6.1.19 SMARTCJS confirmed no contact with Gordon. Following Jessica's self-referral to SMARTCJS, she received a telephone assessment:

*"Currently drinking two bottles of wine daily, stated has cut down and has had dry days. Has a history of drinking for many years and has a full-time job as a freelance journalist that involves drinking. The partner also drinks daily and has referred himself. She stated she doesn't have hangovers or any signs of withdrawal. She previously had anxiety and has felt anxious again. To seek talking therapies".*

6.1.20 A subsequent telephone appointment with the SMARTCJS Keyworker was scheduled for November 2020.

### **November 2020**

6.1.21 Jessica had three telephone contacts with SMARTCJS:

6.1.22 First Contact: She completed a care plan and received an electronic copy, an alcohol support Zoom link, and online guidelines.

6.1.23 Second Contact: Jessica reported using alcohol to manage work stress and emotional distress. While she attempted harm reduction, her drinking increased during stressful events, such as her partner's parents contracting COVID-19 and a panic episode at the supermarket. Financial strain was also a factor, as she supported her unemployed partner, who may have had alcohol issues. The independent reviewer noted potential co-dependency and an enabling cycle in the relationship, requiring further assessment of financial dependency and substance misuse risks.

6.1.24 Third Contact: Jessica reported drinking less, consuming wine thrice a week, and feeling close to her moderation goal. She noted improvements in her mental health and relationship, as her partner helped more with housework and reduced his drinking. No immediate risks were identified.

6.1.25 The independent reviewer recommended ongoing monitoring to ensure the positive changes were sustained, particularly regarding financial and alcohol-related concerns.

### **December 2020**

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<sup>6</sup> <https://www.college.police.uk/support-forces/practices/evidence-led-prosecution-checklist-domestic-abuse-cases>

6.1.26 Jessica's final telephone consultation with SMARTCJS confirmed she had reduced her alcohol intake to three large glasses per week and considered herself an "occasional drinker." Feeling healthier and more confident, she no longer sought support and was discharged.

6.1.27 She stated her partner had also sought support, and she took control of purchasing alcohol while limiting his access to her finances, helping set financial boundaries. However, he remained unemployed and financially dependent on her, which posed a potential power imbalance and stressor.

6.1.28 The independent reviewer noted that while Jessica had made positive changes, her demanding work schedule and ongoing stress could increase the risk of relapse. Dependency and power dynamics remained concerns, highlighting the need for continued support, including domestic abuse services, to maintain stability.

### **January 2021**

6.1.29 Jessica contacted NHS 111 to request support for Gordon through the Crisis Resolution Home Treatment Team (CRHTT).<sup>7</sup> She reported that his depression had worsened since COVID-19, leading to increased anger and withdrawal from services. His aggressive response to CRHTT, "F\*\*\* off," indicated resistance to help and a potential risk to Jessica.

6.1.30 The practitioner noted high stress in their relationship, but both declined to address it. Jessica managed their finances and alcohol access while financially supporting Gordon, whose continued unemployment and emotional instability added strain. His refusal to engage with CRHTT left Jessica in a difficult position.

6.1.31 The independent reviewer highlighted concerns about potential emotional or psychological abuse, even though domestic abuse was not explicitly mentioned. Jessica was provided information on seeking help, and CRHTT closed the case. However, the lack of intervention, including informing Jessica's GP, created a risk gap. Ongoing follow-ups were recommended due to Gordon's declining mental state and the potential for coercion or abuse.

### **March 2021**

6.1.32 TVP received an anonymous report raising concerns about Jessica's welfare, stating that Gordon was physically abusive, strangled and hit her, and that both drank. At the same time, she screamed at him throughout the day. The Neighbourhood Policing Team (NHPT) was assigned to check her welfare and respond to any disclosed offences.

6.1.33 The independent reviewer highlighted that repeated abuse, combined with alcohol use, increased the risk of serious harm. Jessica's daily screaming suggested ongoing distress,

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<sup>7</sup> <https://www.berkshirehealthcare.nhs.uk/our-services/mental-health-and-wellbeing/crisis-resolution-and-home-treatment-team-crhtt/>

potential entrapment, or normalisation of abuse. Her reluctance to seek help raised concerns about coercive control or fear affecting her ability to leave the situation.<sup>8</sup>

### **May 2021**

- 6.1.34 TVP received a report that Jessica and Gordon had been screaming at each other for two days, with a witness hearing Jessica shout, "Ow!" Please call the police." However, the neighbour later reported that no one had been at the address for days.
- 6.1.35 When TVP officers attended, Jessica, visibly intoxicated, stated they had argued over Gordon's new job and her job loss. Inside, Gordon was found highly intoxicated, slurring his speech, and surrounded by empty bottles. He insisted that everything was fine, and neither showed visible injuries.
- 6.1.36 Gordon refused to complete the DASH risk assessment, and the officer marked all responses as "refused," grading the risk as medium. The report listed Jessica as both the victim and the suspect. Information noted that alcohol was affecting Jessica's mental health, but it was unclear if this also applied to Gordon. No further action was taken.
- 6.1.37 The independent reviewer highlighted the increasing risk, chronic intoxication, and barriers to seeking help. Jessica's job loss and ongoing stressors may have heightened her vulnerability to harm.<sup>9</sup>

### **November 2021**

- 6.1.38 A neighbour informed TVP that Jessica and Gordon verbally and physically abused each other at least three times a week. The neighbour reported that Gordon and Jessica intimidated a young family living locally, using racial slurs and threats. The neighbour expressed concern for the family's welfare, suggesting the behaviour amounted to racial bullying.
- 6.1.39 When officers attended, Jessica and Gordon smelled of stale alcohol and showed no visible injuries. Both admitted they might have argued, but could not recall the incident five days earlier. No BWV was recorded.
- 6.1.40 A DASH risk assessment was conducted, but it was noted that "no offences were disclosed." House-to-house inquiries confirmed shouting and swearing but did not determine the target. A supervisory review acknowledged ongoing concerns, and Wokingham Borough Council (WBC) was involved in addressing potential issues related to domestic abuse. However, the family did not feel targeted due to ethnicity, and no further action was taken.
- 6.1.41 The independent reviewer highlighted the chronic, high-risk nature of the situation, exacerbated by alcohol misuse, memory loss, and potential denial or coercive control.

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<sup>8</sup> [https://openaccess.city.ac.uk/id/eprint/19905/1/Myhill%2C%20Andy\\_Redacted.pdf](https://openaccess.city.ac.uk/id/eprint/19905/1/Myhill%2C%20Andy_Redacted.pdf)

<sup>9</sup> <https://vision.city.ac.uk/wp-content/uploads/2024/03/Short-report-Labour-market-consequences-of-IPVA.pdf>

The lack of BWV and missing statements limited opportunities for evidence-based action, and marking "No offences disclosed" may have underestimated the actual risk.

### **December 2021**

- 6.1.42 A 999 call was received, and an ambulance was dispatched to Jessica's home.
- 6.1.43 Jessica experienced two seizures, possibly linked to stress, alcohol withdrawal, or an underlying condition. Although she initially declined hospital treatment, the second seizure required emergency transportation, indicating a serious situation. Jessica reported drinking a bottle of wine daily, a significant increase from her previous intake of three large glasses per week, suggesting a potential relapse in alcohol dependency.
- 6.1.44 Contributing stressors included noisy neighbours, sleep issues, and relationship concerns. Her trouble sleeping may have reflected heightened anxiety or mental health struggles. Additionally, her decline of hospital care, stating she was "too busy", suggested a prioritisation of work over health, which may point to maladaptive coping mechanisms. Her partner witnessed the seizure, but his level of emotional support remained unclear, potentially limiting Jessica's support system amid her challenges.
- 6.1.45 Jessica was seen in the hospital following three seizures and was started on medication. She disclosed to the doctor her relationship with Gordon, in which he would shout at her. The doctor identified and highlighted this as domestic abuse. However, Jessica declined the offer of a domestic abuse referral.
- 6.1.46 The independent reviewer noted that Jessica's declining physical condition and increased alcohol use indicated a troubling trend in her well-being. Her partner's emotional detachment, her potential dependence on him, and domestic abuse may have left her without a strong support system, making her more vulnerable to health and emotional crises.
- 6.1.47 Therefore, her situation merited further examination, especially regarding her rising alcohol intake and seizures. Additionally, it is essential to explore how her relationship may have contributed to her drinking and reluctance to seek medical care. Jessica may have benefited from resources for sleep support and stress management. Furthermore, her partner's role during her seizures should be reviewed to determine if he was able to provide adequate care.

### **January 2022**

- 6.1.48 Jessica had a GP telephone consultation, where she reported no further seizures, indicating effective management with the medication. She also stated that she had reduced her alcohol intake by half, from one bottle of wine per day.
- 6.1.49 During a telemedicine session with RBH, she was advised on seizure safety and instructed to surrender her driving license.

6.1.50 The independent reviewer highlighted the need for continued monitoring to prevent relapse, particularly if stressors persist. Referring to alcohol support services or providing relevant information could help sustain progress. Additionally, the root causes of her alcohol misuse remained unaddressed. Losing her driving licence could impact her independence, employment, and daily life, potentially increasing her vulnerability.

## **June 2022**

6.1.51 Jessica mistakenly called 999 instead of 101 and then abandoned the call. On callback, she reported having an epileptic seizure. When TVP attended, Gordon refused to let officers in, and Jessica spoke to them outside. Both were intoxicated.

6.1.52 Gordon reported that Jessica had a seizure and fell, and he had been managing her epilepsy. Jessica had a bruise near her eye and slight bleeding from her nose, which she attributed to falling and picking something up. She expressed struggles with her epilepsy medication and feeling trapped.

6.1.53 Officers suspected Jessica was withholding information, but found no disclosed offences. She declined the DASH risk assessment. A neighbour confirmed that they had heard an argument earlier that day. Gordon was arrested but denied wrongdoing, and no further action was taken due to a lack of evidence.

6.1.54 The independent reviewer highlighted concerns that coercion or fear may influence Jessica's behaviour.<sup>10</sup> Gordon's refusal to admit officers suggested control, while his role in managing Jessica's epilepsy raised concerns about medical dependency. Their intoxication and frequent arguments pointed to an ongoing pattern of domestic incidents.

## **July 2022**

6.1.55 Jessica informed the epilepsy nurse she had had no seizures since starting the medication, indicating effective epilepsy management. However, the previous month, she had reported seizures due to struggles with her medication.

6.1.56 She experienced improved sleep and fewer panic attacks and significantly reduced alcohol intake, drinking four glasses of wine per week with multiple alcohol-free days. She was also working on reducing smoking.

6.1.57 Initially, Jessica did not respond to the epilepsy nurse, which the independent reviewer suggested could indicate avoidance or barriers to support. She reported worsening irritable bowel syndrome (IBS), often linked to stress or anxiety, suggesting unresolved emotional distress despite her improved seizure control

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<sup>10</sup> <https://www.anncrafttrust.org/resources/disability-domestic-abuse/>

## August 2022

- 6.1.58 After several weeks of being unable to contact Jessica, her parents visited and found her in grave condition, exhibiting severe symptoms such as yellow skin, a bloated stomach, and immobility. Jessica had grade 2/3 pressure sores,<sup>11</sup> was doubly incontinent and had been unable to move for at least three days, suggesting severe neglect. Gordon had not sought medical help, raising concerns about possible neglect.
- 6.1.59 The presence of empty wine bottles indicated chronic alcohol abuse, likely contributing to her decline. Despite Jessica's critical state, Gordon had failed to act, prompting a safeguarding concern from the ambulance crew.
- 6.1.60 Jessica's parents reported a long history of heavy drinking, which had worsened after moving in with Gordon. Potential medical issues, including liver disease and hepatitis, were identified. Jessica also disclosed her partner's alcohol dependency and a history of frequent arguments, indicating emotional and psychological abuse and coercive control.
- 6.1.61 Various services raised safeguarding concerns about bruises, pressure ulcers, and neglect. Jessica's mother described physical, financial, and emotional abuse by Gordon, suggesting a long-standing pattern of coercive control to the AAFDA advocate and independent reviewer.
- 6.1.62 While in the hospital, Jessica was deemed too unwell to discuss domestic abuse and expressed a wish to leave, but the doctor determined she lacked the capacity to make decisions about her discharge.

## Final Stages and Death

- 6.1.63 Jessica's condition rapidly worsened, leading to acute hepatic and respiratory failure, resulting in her admission to the ICU. This decline was likely due to a combination of chronic neglect, alcohol abuse, and untreated medical conditions.
- 6.1.64 Upon admission, Jessica appeared unkempt, reflecting long-term neglect, possibly caused by her partner's refusal to respond to her care needs. She ultimately died in the hospital, a tragic consequence of sustained neglect, medical mismanagement, and domestic abuse.
- 6.1.65 The independent reviewer highlighted concerns about the extent of Jessica's victimisation, including coercive control and physical and financial abuse. The partner's refusal to seek help and his inaction during her decline indicated emotional and psychological abuse, which significantly contributed to her health deterioration and eventual death

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<sup>11</sup> <https://www.gov.uk/government/publications/pressure-ulcers-applying-all-our-health/pressure-ulcers-applying-all-our-health#:~:text=Stage%20%3A%20non%20blanchable,IV%3A%20full%20thickness%20tissue%20loss>

## Section Seven: Analysis of Agencies Contact

### Adult Social Care (ASC)

- 7.1.1 **Safeguarding Concern:** Jessica's admission to RBH triggered a "red" safeguarding concern due to an immediate risk of harm, which required urgent protective actions. The ASC Team Manager should have been notified following the legal obligations outlined in Section 42 of the Care Act (2014).<sup>12</sup>
- 7.1.2 **Inability to Engage in Section 42 Enquiry:** ASC could not conduct a Section 42 Safeguarding Adult Enquiry because Jessica was too ill to engage, and she tragically died before further steps could be taken. Section 42 enquiries are designed to investigate abuse or neglect and determine protective measures, which was impossible in this case.
- 7.1.3 **Decision for DHR:** The Safeguarding Adult Review Panel determined that Jessica's case did not meet the Section 44 Care Act enquiry criteria<sup>13</sup> instead opting for a DHR as there were suspicions that her death may have involved domestic violence or abuse.
- 7.1.4 **Purpose of DHR:** Given the complexity of Jessica's situation, the decision to follow the DHR process aimed to investigate the circumstances of her death and identify lessons to prevent similar domestic abuse-related deaths in the future.

### GP Practice

- 7.1.5 **Jessica's GP Contacts:** Jessica registered with the GP practice in 2021 and recorded two visits in January 2022: one for health concerns related to seizures and alcohol, and another for the COVID-19 vaccination. These indicate routine engagement with healthcare services.
- 7.1.6 **Domestic Abuse Identification:** The GP practice had no record of domestic abuse or safeguarding concerns during Jessica's visits and did not identify any signs of abuse.
- 7.1.7 **Role of Healthcare Providers in Domestic Abuse Identification:** Safe Lives stresses that healthcare providers, particularly GPs, play a critical role in identifying domestic abuse victims. Many victims seek medical care during or after abusive incidents, positioning healthcare professionals to detect abuse signs.<sup>14</sup>
- 7.1.8 **Data on Healthcare and Domestic Abuse:** According to House of Commons data, approximately 0.5 million survivors interact with healthcare services annually,

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<sup>12</sup> <https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted>

<sup>13</sup> <https://www.legislation.gov.uk/ukpga/2014/23/section/44/notes>

<sup>14</sup> [https://safelives.org.uk/Whole\\_Health\\_London#:~:text=Whether%20a%20GP's%20surgery%2C%20a,provide%20immediate%20support%20and%20information](https://safelives.org.uk/Whole_Health_London#:~:text=Whether%20a%20GP's%20surgery%2C%20a,provide%20immediate%20support%20and%20information)

underscoring the importance of training healthcare professionals to recognise victims of domestic abuse.<sup>15</sup>

**7.1.9 Routine Domestic Abuse Inquiries:** The Department of Health recommends routine inquiries about domestic abuse in healthcare settings to create a safe space for disclosure and enable healthcare providers to intervene appropriately. However, a model of selective enquiry is more practicable within primary care.<sup>16</sup>

**7.1.10 Importance of GP Practices in Addressing Domestic Abuse:** While no specific safeguarding concerns were raised during Jessica's healthcare visits, this section highlights the critical role that GP practices and healthcare settings have in recognising and addressing domestic abuse, as they often serve as the first point of contact for victims.

### **Royal Berkshire Hospital NHS Foundation Trust (RBH)**

**7.1.11 Domestic Abuse:** RBH recognised the signs of domestic abuse during Jessica's December 2021 admission and discussed a referral to Berkshire Women's Aid. However, a risk assessment was not conducted, nor was there a multi-disciplinary discussion, despite indications of emotional abuse and alcohol misuse. Jessica's minimisation of the abuse likely led to underestimating the associated risks.

**7.1.12 Telemedicine Reliance:** Jessica received care from the neurology service via telephone consultations with an epilepsy nurse, highlighting the increasing reliance on telemedicine since COVID-19. However, her family was concerned that an in-person consultation was necessary to better assess her condition, particularly given her reported lack of appetite, which the nurse attributed to her medication.

**7.1.13 Concerns About Telemedicine Limitations:** The growing use of telemedicine at RBH was due to longer wait times for in-person visits. While convenient, telemedicine can miss crucial aspects of care, such as physical signs of deterioration.<sup>17 18</sup> Jessica's family felt an in-person visit would have provided a more accurate understanding of her health.

**7.1.14 Medication Impact:** Jessica's medication can cause weight loss, which may have contributed to her appetite issues.<sup>19</sup> She also reported efforts to reduce alcohol consumption, which can interfere with her medication's effectiveness and worsen side effects.<sup>20</sup>

<sup>15</sup> <https://commonslibrary.parliament.uk/research-briefings/cbp-9233/>

<sup>16</sup> <https://assets.publishing.service.gov.uk/media/5a7f850940f0b6230268ffbba/DomesticAbuseGuidance.pdf>

<sup>17</sup> <https://www.rcpjournals.org/content/clinmedicine/20/4/e104>

<sup>18</sup> <https://www.sciencedirect.com/science/article/pii/S1059131117306672>

<sup>19</sup> <https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1528-1167.2007.01273.x>

<sup>20</sup> <https://alcoholrehabhelp.org/interactions/drugs-and-alcohol/keppra/>

- 7.1.15 **Family's Concerns:** Jessica's family raised concerns to the independent reviewer about her medication dosage and its impact on her appetite, highlighting the psychological strain of uncertainty regarding her treatment.
- 7.1.16 **Independent Reviewer's Observation:** The reviewer noted that while telemedicine is valuable, it has limitations, particularly when assessing physical symptoms such as weight loss. The combination of alcohol, epilepsy medication, and Jessica's health issues made her condition difficult to manage remotely.
- 7.1.17 Additionally, concerns about potential abuse by her partner, Gordon, underscored the need for improved safeguarding and better communication between healthcare providers, patients, and families. In-person assessments and proactive family involvement might have helped identify risks earlier.

### Thames Valley Police (TVP)

- 7.1.18 **Domestic Incident and Delays in Response:** The first recorded domestic incident between Jessica and Gordon occurred in March 2020. Jessica participated in the DASH risk assessment, which was graded as medium risk but did not support the investigation. The case was referred to MASH but delayed in review by Berkshire Women's Aid, ultimately leading to its closure. This highlighted weaknesses in inter-agency coordination and delays that affected victim safeguarding.<sup>21</sup>
- 7.1.19 **Coercive Control Dynamics:** Gordon's minimisation of his actions and the incident involving strangulation indicated a high-risk form of domestic abuse despite a lack of visible injuries.<sup>22</sup> Strangulation is a key indicator of escalating abuse.<sup>23</sup> Jessica's reluctance to cooperate is a known barrier in such cases, necessitating proactive safeguarding and effective engagement with victims for improved safety outcomes.<sup>24</sup>
- 7.1.20 **Impact of COVID-19:** The COVID-19 restrictions likely influenced access to support services and reporting, complicating the response to domestic incidents.
- 7.1.21 **Domestic Disturbance in October 2020:** A subsequent incident in October 2020 involved Jessica and Gordon, with Jessica intoxicated and Gordon injured. The failure to complete a DASH risk assessment during this event and gaps in identifying vulnerability in custody highlighted shortcomings in addressing mental health and safeguarding concerns.
- 7.1.22 **Systemic Gaps in Custody Process:** Jessica's vulnerability was not fully assessed in custody, failing to meet established risk assessment protocols.<sup>25</sup> Additionally, no

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<sup>21</sup> <https://www.local.gov.uk/sites/default/files/documents/National%20analysis%20of%20SARS%20-%20Stage%202%2028branded%20and%20proofread%29%20v6-19.pdf>

<sup>22</sup> <http://dx.doi.org/10.1093/oso/9780197639986.001.0001>

<sup>23</sup> <https://doi.org/10.1016/j.jemermed.2007.02.065>

<sup>24</sup> <https://www.exchangechambers.co.uk/victimless-prosecution-applying-and-resisting-res-gestae/>

<sup>25</sup> <https://www.gov.uk/government/publications/pace-code-c-2019/pace-code-c-2019-accessible>

intervention was conducted for potential mental health issues. These issues were attributed to officer inexperience, leading to a call for improved training and supervision.

7.1.23 **March 2021 Anonymous Report:** An anonymous report highlighted Gordon's physical abuse toward Jessica, including strangulation. A Police Community Support Officer (PCSO), who was not trained to handle such cases, was assigned to visit the home, but no record was found. This reflected human error and a systemic gap in ensuring that domestic abuse information was tracked correctly and followed up.

7.1.24 **November 2021 Domestic Incident:** In November 2021, a domestic incident report showed that both Jessica and Gordon were intoxicated. The situation suggested ongoing domestic dysfunction and alcohol misuse. Still, the absence of BWV footage and unclear details regarding Gordon's role in the incident underscored the need for further investigation and monitoring.

7.1.25 Overall, the system had multiple gaps, including delays, a lack of coordination, and a failure to complete necessary assessments, contributing to missed early intervention and safeguarding opportunities.

## Section Eight: Key Issues Arising from the Review/Lessons Learned

### Coercion and Control

8.1.1 The DHR highlights the significant impact of coercive control in Jessica's abuse, showing how it undermined her autonomy, isolated her, and made her dependent on Gordon. The abuse included controlling her independence, career, and finances, as well as limiting her access to support services, especially during the COVID-19 pandemic.

#### Key lessons include:

1. Coercive control is as damaging as physical violence and must be recognised in domestic abuse cases.
2. Comprehensive risk assessments should address not only physical violence but also patterns of psychological and emotional abuse.
3. Financial control should be considered a key component of coercive control, and agencies should provide support for victims facing financial abuse.
4. Reluctance to engage with support services often stems from coercive control, highlighting the need for sensitive, proactive engagement.
5. Coercive control has severe health impacts, and healthcare professionals must be trained to identify signs of abuse in vulnerable patients.

8.1.2 The DHR emphasises the importance of recognising and addressing coercive control to safeguard victims better.

## Information Sharing

8.1.3 The DHR underscores the critical need for effective information sharing among agencies in domestic abuse cases to ensure timely interventions and reduce risks to victims.

### Key lessons include:

1. Ineffective information sharing between TVP, RBH and SMARTCJS resulted in missed opportunities for intervention, underscoring the need for improved coordination and communication.
2. Clear referral pathways must be established to ensure victims receive appropriate support, particularly when coercive control is identified.
3. Collaboration between professionals is crucial for comprehensive care and vulnerability assessment, with information-sharing protocols between agencies.
4. The COVID-19 pandemic and social distancing measures reduced the number of in-person consultations, limiting communication and support for victims.
5. Consent for information sharing should be carefully managed, balancing confidentiality and the need to safeguard individuals. Sometimes, information should be shared without consent if there is a serious safeguarding concern.
6. Coordinated efforts across agencies, utilising shared systems and multidisciplinary teams, leading to more effective decision-making and intervention in domestic abuse cases.

8.1.4 The DHR emphasises the importance of inter-agency collaboration and clear communication to support victims better and prevent further harm.

## Economic Abuse

8.1.5 The DHR highlights key lessons about economic abuse as a form of coercive control that is often overlooked in domestic abuse cases.

### Key insights include:

1. Economic abuse involves controlling a victim's finances, undermining their independence and ability to escape the abuser. Jessica's DHR illustrates this, with Gordon controlling her finances and possibly continuing to exploit her accounts after her death.
2. Financial exploitation, like cancelling bank cards or using them without consent, demonstrates the vulnerability of victims, making them dependent on the abuser and often unable to seek help or leave the relationship.
3. Economic abuse can lead to severe poverty and increased dependency, leaving victims feeling powerless or ashamed to speak out. This underscores the

importance of proactive screening for financial abuse in domestic abuse situations.

4. Coercive control over financial resources can also include restricting access to communication (e.g., hiding phones), isolating the victim from support, and limiting access to work or resources.
  5. The DHR reveals how economic abuse can entrap victims, particularly when the abuser controls all financial resources, as seen in Jessica's case, where she was the sole income earner.
  6. Many women facing economic abuse, like Jessica, struggle with financial dependency, which prevents them from seeking help or leaving abusive relationships. This training gap in recognising economic abuse as part of domestic abuse needs addressing, as seen in Jessica's interactions with SMARTCJS.
  7. Early identification of economic abuse is crucial for intervention, as it empowers victims to regain financial independence, ultimately enabling them to make safer and more independent choices.
- 8.1.6 The DHR emphasises the need for better recognition and addressing economic abuse as part of the broader response to domestic abuse.

### **Intersectionality and Domestic Abuse**

- 8.1.7 Jessica's DHR highlights the intersection of alcohol use, physical health, and domestic abuse, illustrating how these factors can compound a victim's vulnerability and complicate their ability to escape abusive situations.

#### **Key insights include:**

1. Alcohol consumption significantly impacted Jessica's health and her relationship with Gordon. Both drank alcohol above the recommended guidelines. Alcohol often acts as a coping mechanism and enables abuse. Routine screening for alcohol use should be included in domestic abuse risk assessments, especially when substance misuse is present.
2. Health decline: Jessica's epilepsy and alcohol use contributed to significant health issues, including weight loss, malnutrition, and pressure sores. Despite regular healthcare interactions, these physical issues were not adequately addressed. The importance of a holistic healthcare approach is emphasised, particularly for patients with chronic conditions and substance misuse.
3. The combination of alcohol misuse, epilepsy, and domestic abuse heightened Jessica's vulnerability, making it difficult for her to escape. Economic dependency on Gordon and her health conditions further limited her ability to seek help.
4. The intersectionality of gender, health, and socioeconomic status created unique vulnerabilities for Jessica, which compounded her experience of domestic abuse.

5. Holistic assessments are essential in cases with overlapping issues such as health, substance misuse, and domestic abuse. A multidisciplinary approach involving healthcare, domestic abuse services, and substance misuse support is necessary to address victims' complex needs.
6. Individuals with physical or mental health issues like epilepsy are often particularly vulnerable to domestic abuse. Targeted support and safeguarding plans should be in place for individuals with chronic health conditions to ensure they receive the care and attention they need.
7. Neglect is a significant indicator of domestic abuse, and agencies must be vigilant for signs of neglect, especially in vulnerable individuals. Collaborative efforts between healthcare and domestic abuse services are essential to address both immediate safety concerns and long-term health needs.
8. Substance misuse and chronic health conditions can exacerbate a victim's vulnerability, making it harder for them to seek help or escape the abuse.

8.1.8 The DHR emphasises the need for integrated services to support individuals facing multiple challenges, ensuring a comprehensive approach to healthcare, domestic abuse, and substance misuse issues.

### **Community and Family Awareness of Domestic Abuse**

8.1.9 The DHR of Jessica highlights the crucial role of family and community in recognising and supporting victims of domestic abuse, stressing the need for greater awareness of its signs and interventions.

#### **Key insights include:**

1. Family involvement: Jessica's family was deeply concerned about Gordon's abusive relationship, recognising his controlling behaviour, including financial exploitation and isolation. However, they struggled to engage her effectively. This underscores the importance of family awareness in recognising abuse despite barriers like fear or lack of knowledge.
2. Barriers to intervention: Family members face challenges, including fear and uncertainty, when trying to intervene in domestic abuse situations. Raising awareness for families and friends about the signs of abuse and how to help is critical, along with ensuring that support networks can assist without compromising their safety.
3. Community awareness: Broader community recognition of domestic abuse is vital for identifying victims and offering support. Education and awareness programs should be expanded to help community members recognise abuse and know how to intervene safely. Public awareness should cover all forms of abuse, including economic, emotional, and physical, and provide resources like domestic abuse helplines.

4. Family challenges: Jessica's family felt helpless due to her financial dependency and health issues, making it difficult for them to intervene. They were concerned that Jessica might not fully disclose the extent of the abuse, highlighting a need for domestic abuse services to address disclosure barriers and make support more accessible.
5. Communication gaps: A key issue in Jessica's case was the lack of communication between agencies, which hindered a coordinated response. Despite family concerns, they were unaware of domestic abuse services or interventions. Information-sharing protocols are essential for keeping families informed while respecting privacy laws and should include training on recognising abuse and engaging with service providers.
6. Vulnerability and isolation: Jessica's health condition, particularly her epilepsy, increased her vulnerability, as it made her more reliant on Gordon and isolated her from her social life. Community and family support must be tailored to the unique needs of vulnerable victims, ensuring they receive the necessary support for their safety and independence.
7. Multi-agency collaboration: The DHR emphasises the need for multi-agency collaboration to ensure a coordinated response that supports the victim's immediate safety and long-term well-being. Strengthening community awareness and support networks is crucial for an effective response to domestic abuse.

8.1.10 The DHR stresses that family and community support systems, when well-informed and resourced, can play a key role in preventing and intervening in domestic abuse cases.

**Thames Valley Police highlighted key learning points in the DHR of Jessica:**

8.1.11 Organisational Learning:

1. DASH Risk Assessments: Incomplete responses in risk assessments must be addressed to ensure accurate risk grading and effective information sharing.
2. Supervision: Sergeants must ensure DOM5 risk assessments are fully completed and errors are identified.

8.1.12 Departmental Learning:

1. NHPT Information Sharing: Failure to act on information about potential abuse highlights the need for a prompt response and system updates.

8.1.13 Individual Learning:

2. Risk Assessment Completion: DASH assessments should use previous data and incident info when victims don't engage.

3. Sergeant's Review: Sergeants must ensure risk assessments are complete before ratifying them.
4. Vulnerability Assessments: Officers missed assessing mental health and alcohol dependency. These should be flagged for further referral.
5. Injury Documentation: All injuries should be documented, and the reasons for any missing records should be explained.
6. Sergeant's Report: Reports must include clear and complete details to ensure proper follow-up actions.

8.1.14 These learning points emphasise the need for thorough assessments, better supervision, and effective communication within TVP to safeguard victims.

## Section Nine: Conclusion

- 9.1.1 The DHR examines the circumstances leading to Jessica's death in September 2022, focusing on her victimisation, her relationship with Gordon, and interactions with various agencies.
- 9.1.2 **Controlling Behaviour & Alcohol Misuse:** Jessica's relationship with Gordon involved controlling behaviour and alcohol misuse, with both often intoxicated during police visits. Despite risk assessments, domestic abuse went unaddressed due to their reluctance to engage with domestic abuse services.
- 9.1.3 **Missed Opportunities for Support: Jessica sought help for alcohol use in 2020 but had no further engagement after December 2020.** Her health declined significantly, and serious neglect, such as malnutrition and dehydration, was evident in her August 2022 hospitalisation, which could have been caught with in-person assessments.
- 9.1.4 **Key Lessons:** The review identifies poor inter-agency communication, failure to recognise the impact of domestic abuse on Jessica's health, and lack of adequate support for individuals with substance misuse. It stresses the importance of coordinated efforts, early intervention, and personalised care to prevent future tragedies.

## Section Ten: Recommendations

### Multi-Agency Recommendations

- 10.1.1 Since Jessica's death, SMARTCJS has revised its management structure and services. Consequently, the recommendations have not been specifically tailored to their service. Nevertheless, the learning from the DHR will be taken forward in their new structure.
- 10.1.2 **Recommendation One: Coercion, Control and Routine/Selective Enquiry**

10.1.3 The need for better understanding and proactive measures around coercive control in domestic abuse cases is critical. Coercive control, which involves behaviours aimed at dominating and isolating victims, can lead to severe violence or homicide.

10.1.4 Routine enquiry involves systematically questioning individuals about potential abuse during interactions with healthcare and social services, ensuring early detection of abuse even if victims do not disclose it.

### **Royal Berkshire NHS Foundation Trust (RBH) and Thames Valley Police (TVP)**

1.1 Enhanced Training for Front-Line Staff in Understanding Coercive Control: Practitioners in various sectors should receive comprehensive training to identify and respond to coercive control, including its nuanced manifestations and substantial risks.

1.2 Routine/Selective Enquiry Implementation: The review has emphasised the necessity of consistent follow-up and enquiries, as domestic abuse is often concealed. Frontline staff should have access to training to conduct routine/selective enquiries effectively, establishing a secure environment for victims to disclose abuse.

### **10.1.5 Recommendation Two: Information Sharing**

10.1.6 Effective information sharing among agencies is crucial in preventing domestic abuse and safeguarding victims.

### **RBH and TVP**

2.1 Agencies should deliver targeted training/resources to frontline staff on when it is appropriate to share information related to domestic abuse. The training should cover key legal thresholds, safeguarding duties, and confidentiality principles.

### **Thames Valley Police**

2.2 Maintain updated domestic abuse resources that provide easy access to resources and support services.

### **10.1.7 Recommendation Three: Economic Abuse**

10.1.8 Economic abuse is a prevalent form of domestic abuse in which perpetrators restrict the autonomy and ability of their partners to flee the abusive environment by controlling their financial resources.

### **Wokingham Community Safety Partnership**

3.1 CSP to create resources, including pathways for survivors to open independent bank accounts, access credit, and secure stable housing.

#### **10.1.9 Recommendation Four: Alcohol Misuse, Physical Health and Domestic Abuse**

10.1.10 Alcohol misuse can worsen domestic abuse and harm physical health. While not the direct cause, it can increase the frequency and severity of abusive incidents. A comprehensive approach focusing on prevention, intervention, and support is essential to address this issue.

#### **Cranstoun Services, RBH and TVP**

4.1 Front-line practitioners have access to training and resources for therapeutic approaches that acknowledge the impact of trauma on individuals, enabling them to customise interventions to address both the psychological and behavioural aspects of abuse and addiction.

#### **10.1.11 Recommendation Five: Community and Family Awareness of Domestic Abuse**

10.1.12 Raising community and family awareness of domestic abuse is crucial for support and prevention. By implementing educational and empowerment strategies, communities can create environments where abuse is recognised early and victims receive help.

#### **Wokingham Community Safety Partnership**

5.1 To organise a community session in conjunction with local domestic abuse services for the public on the identification and prevention of domestic abuse, and providing support resources.

10.1.13 The panel agreed that the recommendation required a broader approach than Wokingham since Jessica's family and friends lived elsewhere. As a result, the independent author sought advice from the College of Policing, the Commissioner for Domestic Abuse, and Refuge.

10.1.14 Refuge recommended the following links to support this recommendation:

- [Survey Reveals Gaps in Nations' Awareness of Red Flags of Domestic Abuse](#)
- [Coercive Control - Refuge](#)
- [Homepage - National Domestic Abuse Helpline](#)

Wokingham CSP is responsible for monitoring the implementation of the action plan. The actions are intended to facilitate safer and more effective responses to domestic abuse victims and survivors. This must be emphasised to ensure that agencies are accountable for completing their actions.

