Gloucestershire
Learning Brief: Domestic Abuse Related Death Review (DARDR)
Jennifer - 2020

1. Purpose

This brief summarises the key learning from the rapid review into the deaths of Jennifer, a 43-year-old woman who died by suicide while under mental health care. The review was commissioned after her death was identified as meeting the statutory criteria for a DARDR.

2. Agency Involvement

British Army, Gloucestershire Constabulary, Gloucestershire County Council, GDASS, Gloucestershire Health and Care NHS , Foundation Trust, GRASSAC, NHS Gloucestershire ICB, Stroud Beresford Group, Stroud Community Safey Partnership, Safer Gloucestershire

3. Key findings

Complex Trauma and Abuse

Jennifer experienced significant childhood trauma and long-term domestic abuse including physical, sexual, economic and coercive control both during and after her marriage. The abuse continued post-separation, with the perpetrator exploiting her mental health vulnerabilities to maintain control.

Impact on mental health

The cumulative effect of trauma and ongoing abuse led to severe mental health decline; repeated suicide attempts and ultimately her death. Jennifer's help-seeking was consistent, but her disclosures were often minimised or pathologized by professionals.

Systematics Gaps

Agencies tended to view incidents in isolation, focusing on Jennifers mental health rather than recognising the broader pattern of coercive control. Multi-agency safeguarding was inconsistent, with missed opportunities for coordinated action especially around discharge planning and MARAC referrals.

Military context

The military environment contributed to Jennifer's isolation and fear, with unique barriers to disclosure and support. Information sharing between civilian and military agencies was limited and the dual role of welfare officers undermined victim trust.

Children's experience

The impact of abuse extended to Jennifers children, who showed signs of emotional distress ad conflicting loyalties. Safeguarding responses often focused on Jennifer's mental health, overlooking the children's lived experience of domestic abuse.

4. Learning Points

Domestic Abuse and Suicide

Suicide risk should be recognised as a direct consequence of domestic abuse, not just a co-occurring mental health issue. Victims may feel trapped and hopeless with suicidal ideation escalating in response to ongoing abuse.

Post-separation abuse

Separation does not guarantee safety, post-separation abuse can intensify, especially when perpetrators use children, legal processes or remote tactics to maintain control.

Trauma Informed Practice

Agencies must adopt a trauma-informed victim-centred approach, proactively identifying patterns of control to disrupt them. Conditional support and victim blaming language must be challenged.

Multi-agency coordination

Effective safeguarding requires robust information sharing consistent use of risk assessments tools and inclusion of all relevant agencies inclusion military representatives in key meetings.

Children as victims

Children living with domestic abuse are victims in their own right. Their voice and experiences must be central to safeguarding responses.

5. Recommendations

Ensure all agencies attend key safeguarding meetings.

Integrate trauma-informed, dynamic risk assessments to staff training.

Recognise suicide as a safeguarding issue in domestic abuse cases.

Regularly audit multi-agency meetings to identify and address missed risks.

Develop clear information sharing protocols between the Police and military.

Review domestic abuse training for both civilian and military professionals to address specific risks and barriers for military families.