Gloucestershire

Domestic Abuse Related Death (Rapid) Review

Jennifer died in March 2020

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Pen portrait of Jennifer

Jennifer was 43 years old when she died. She was a mother of three children and had lived for many years within the military community. She had attended private school and later studied dance at university. Jennifer was of Jewish faith, although the review has not been able to establish how central this was to her day-to-day life.

Jennifer had experienced trauma from a young age, in adulthood, she then disclosed domestic abuse during and after her marriage to Michael (a service Amry officer). The cumulative impact of this abuse, alongside earlier trauma, had a significant effect on her mental health and wellbeing.

Throughout the period considered by this review, Jennifer sought help from a range of agencies. She shared her fears, described the abuse she was experiencing, and tried to access support for herself and her children.

Jennifer should be remembered not only through the circumstances of her death, but as a mother, a woman with her own identity and life experiences, and someone who repeatedly tried to be heard. Her death highlights the need for professionals to recognise the links between domestic abuse, trauma, mental health and suicide, and to respond with curiosity, compassion and coordinated safeguarding action.

Preface

Safer Gloucestershire, panel members and the author wish, at the outset, to express their deepest sympathy and condolences to Jennifer's family. This review has been undertaken in an open and constructive manner, with all agencies engaging positively, which has ensured we have been able to consider the circumstances of Jennifer's death in a meaningful way, and address with candour any issues raised.

1. Introduction

1.1 In 2020, Jennifer, a 43-year-old woman, died by suicide whilst a patient at a mental health hospital in Gloucestershire. At the time, Safer Gloucestershire was not notified of Jennifer's death, and a Domestic Abuse Related Death Review (DARDR) was not commissioned at the time. During a countywide suicide case audit in 2025, Jennifer's death was identified as meeting the statutory requirements as set out in Home Office

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Multi-Agency Statutory Guidance for Domestic Homicide Review 2016[1] and Domestic Violence, Crime and Victims Act 2004[2]. Due to the passage of time that had passed since the death, the Home Office agreed for a Rapid Review to take place, ensuring the guidance was used.

1.2 To support the rapid review, the Social Care Institute for Excellence's (SCIE) 'Reviews in Rapid Time' (SARiRT)[3] guidance and templates were also used. A SARiRT is a methodology and series of tools that aim to allow learning to be turned around swiftly, with limited demand on participants' time.

1.3 Due to the length of time between Jennifer passing away to the commissioning of a review, a decision was made not to contact the family. To protect the identity of those involved, pseudonyms have been used; these were chosen by the chair and agreed by the panel.

1.4 The chair and all those involved in the review were independent of any work carried out with Jennifer or her family. Agencies provided a Rapid Review Report of their interactions and attended an in person learning event to discuss key episodes, themes and reflections to enhance learning. Those involved can be found in Appendix 2.

1.5 All IMRs and summary reports will remain confidential and will not be shared. The reports will be available on Gloucestershire Council's website and disseminated to the Domestic Abuse Commissioner, Gloucestershire's Office for Police and Crime Commissioner (OPCC), the Chief Executive (or equivalent) for all agencies represented on the panel and the Gloucestershire Community Safety Partnership Board and Domestic Abuse Partnership Board, the Home Office and Domestic Abuse Commissioners office.

2. Jennifer's life and circumstances

2.1 Jennifer was a white British woman, she had experienced childhood trauma after a friend died when Jennifer was 8 years old, she overdosed at 13 years old, was diagnosed with Bell Palsy[4], suffered with bulimia throughout her teenage and adult years and was raped at the age of 15.

2.2 Jennifer went to private school and then University where she went to study dance; whilst there she met Michael (she was 18 years old) and was pregnant within 18 months (she did not complete her studies). Jennifer disclosed to agencies that there had been domestic abuse throughout her marriage to Michael: they were married for 19 years before divorcing in 2019. Together they had three children, one who was over 18 years old and two under 18 years old at the time of her death. Michael was a senior ranking officer in the army and the family lived in army marriage quarters until their separation.

2.3 Jennifer was of Jewish faith, however, it is unclear if Jennifer or the rest of the family practiced this religion and whether it had any impact on the relationship. The charity Shifrah UK[5] provides insight into the cultural and religious expectations within families. It highlights that there may be misuse of religious teachings and spiritual practices to exert control. Additionally, when a "Gett" (divorce document) is requested, the only way it can

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[2] https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004
[3] https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time/
[4] https://www.nhs.uk/conditions/bells-palsy/
[5] https://www.shifrah.org.uk/blog/a0rqw2ixyg2r3x0f8upwualt8amhm0

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be granted is by the husband willing for the marriage to be resolved. Refusal is a devastating form of religious abuse in the Jewish community and will prohibit a woman to remarry within the faith. Abusive husbands may refuse to grant the "Gett", trapping women in a state of limbo and maintaining control. This can lead to fear of bringing shame to the family or community, isolating victims and discouraging them from accessing support. Although the review cannot be certain this occurred, it has identified that Michael refused the divorce over a period of 18 months, causing distress to Jennifer. This does not mean this was definitively a feature of Jennifer's experience, but it does highlight the importance of professionals asking sensitive questions about faith, culture, divorce, family expectations and community pressures when assessing domestic abuse risk.

2.4 Jennifer's identity and circumstances should be understood through an equality and diversity lens. She was a white British woman, a mother, a Jewish woman, a military spouse, and someone experiencing significant mental ill-health and trauma. These characteristics and life circumstances may have shaped both her experience of abuse and the way she engaged with services. While the review has not found evidence that agencies directly discriminated against Jennifer, it is important to recognise how assumptions about class, education, military status, mental health, motherhood and religion may have influenced professional understanding of her needs and risks.

2.5 Jennifer's position within the military community was particularly relevant. As the wife of a senior ranking army officer, she lived within a community where hierarchy, reputation, housing, finances and social expectations could create additional barriers to disclosure and help-seeking. Victims in military families may fear that reporting abuse will affect the serving person's career, family stability, accommodation or income. In Jennifer's case, her concerns that Michael's rank and status affected whether she would be believed should have prompted greater professional curiosity and a more explicit consideration of power, status and institutional context.

2.6 It is also important to recognise Jennifer's mental health in the context of trauma and abuse, rather than as an isolated issue or personal failing. Her self-harm, suicidal ideation and difficulty sustaining engagement with services should have been understood as potential indicators of cumulative trauma, coercive control and entrapment. A trauma-informed equality approach requires professionals to consider how mental health, victimisation, gender, parenting responsibilities and social position intersect to affect a person's ability to seek help, be believed and achieve safety.

2.7 Jennifer alleged domestic abuse, including rape, sexual assault, coercive control, economic abuse and harassment during her marriage and post-separation. The childhood trauma and the trauma from the abuse within her relationship had a significant impact on her mental health and wellbeing. Shortly before Jennifer died, she was voluntarily staying at a hospital to support her mental wellbeing; throughout her stay she made allegations of continued abuse and cited this as a reason for her suicidal ideation.

3. Key episodes

2016

3.1 Jennifer sought support from GDASS regarding domestic abuse. Due to domestic abuse within the family home, social care was also involved.

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2017

3.2 Jennifer disclosed that her wages were being paid into a joint account which she had no access to. She also shared that she had discovered they were in debt to the children's boarding school for approximately £3000.

3.3 Jennifer shared with GDASS that the abuse escalated when the children were home from boarding school, and that her eldest child was challenging Michael and the two younger children were showing challenging behaviour at school.

3.4 Jennifer and Michael separated; as a result, Jennifer received an eviction notice from the army. Jennifer was placed in refuge; GDASS then supported Jennifer to secure her own tenancy and access support with benefits and finances.

3.5 Michael started to receive support from the Army Welfare Service and attended a 1 day Stress and Resilience course to learn positive coping strategies due to struggling to maintain a healthy work-life balance. He also shared he was experiencing low periods of mood and described himself as a "Broken Man".

3.6 Jennifer was admitted to hospital after taking an overdose; after this she told the social worker that Michael was abusive towards her, but not the children.

3.7 Jennifer contacted Police and made an allegation of sexual assault, rape and threats to kill from Michael. He was arrested, where he denied the rape but stated during an argument, he had threatened to stab Jennifer, but that she had manipulated the argument. Michael was placed on bail. The army provided Michael with accommodation to ensure he did not breach his bail conditions. Michael was removed from his post with the Regiment and, due to the allegations against him, he withdrew from coaching his son's rugby team. Michael informed the army welfare officer that he was in receipt of counselling and had completed the SPLITZ Turnaround programme questionnaire, which indicated his behaviours may have been damaging to his relationship.

3.8 Due to the allegations made, Jennifer was referred to MARAC, however, a decision was made not to hear the case. Several Child in Need meetings were held over the second half of the year.

2018

3.9 Michael was signed off work due to the stress of the allegations against him. Contact with the children was also stopped; however, this resumed later in the year.

3.10 During a conversation with Stroud Beresford Group, Jennifer disclosed that Michael continued to control her phone, her movements and her finances. She felt no one believed her due to his position in the army and she was concerned that social care had closed her case.

2019

3.11 Jennifer started a new job (there are no records to indicate what this was). One of the children's schools raised concerns that they were not attending school. Jennifer told the

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school that it was due to them being bored, however, there was very little evidence of this when he was in class.

3.12 Jennifer disclosed to her GP on multiple occasions that she was self-harming and struggling with anxiety, however, insisted she was not suicidal.

3.13 Jennifer told her Stroud Beresford Group support worker that Michael had been to the house and spent some time with her and the children. She was feeling confused as the children seemed happy that he was in her home, and they thought everything would go back to normal.

3.14 Jennifer's mental health started to decline as her self-harming by cutting and suicide attempts increased, citing Michael's behaviour as the reason behind her actions. During this time, Michael was attending her home more often to look after the children (during the day but not staying overnight).

3.15 After Michael had initially refused the divorce request, the divorce was finalised at the end of the year.

2020

3.16 The school became concerned of domestic abuse after Jennifer's child writes a story about his family; within this, it indicates domestic abuse within the family home.

3.17 A Team Around the Family meeting was held to ensure all those working with the family were aware of the concerns around Jennifer's mental health.

3.18 Jennifer's mental health continued to decline, and she told her Stroud Beresford Group support worker that Michael was refusing to leave her home even though she had asked him to. She alleged he had blackmailed her by threatening to take her children away if he could not stay at her home. Shortly after this, her suicidal ideation escalated, and she voluntarily stayed at a mental health hospital. As a result, a DASH was completed, and Jennifer was referred to MARAC.

3.19 After receiving the DASH, the MARAC coordinator informed the Police of the information, who recorded coercive and controlling behaviour on their system.

3.20 Concerns were raised that Jennifer was suicidal after making comments to her mental health worker including "*no one can help me and from Wednesday this week it won't matter any way*" and "*no one - not anything can stop Michael*" and she felt it was "*an impossible situation*". The family's case was heard at a strategy meeting due to concerns over Jennifer's mental health.

3.21 Jennifer told her Stroud Beresford Group support worker that Michael had left her home, but he would be returning, and she was concerned that he was questioning the children about what they ate for tea and why there is still washing up in the sink.

3.22 Jennifer was reported missing to the Police after her care coordinator was concerned for her welfare after she had shared thoughts of taking an overdose. Police and a Mental Health Car located Jennifer; she told them that she did not want to return home because Michael was a source of anxiety and he had a negative impact on her. They determined

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there was no need to detain Jennifer under S136, however, a cause for concern was raised to the community mental health services.

3.23 Jennifer started to purchase sodium nitrate online to take her life, concerns escalated regarding her suicidal ideation, and she voluntarily stayed at a local mental health hospital. Whilst in the hospital, Jennifer shared that she had nightmares of past trauma, had '*nowhere to go*', has been researching suicide and wanted to '*be free of him (Michael)*'. Michael called the ward insisting they inform him of the plans for Jennifer as he had been left with the children. Jennifer disclosed a sense of hopelessness and that she felt Michael was winning, turning her children against her and that no-one could stop him.

3.24 A S47 assessment was completed which resulted in a meeting at one of the children's school five days before Jennifer's death. Within this meeting the social worker was actioned to 'ask' Michael to leave Jennifer's home prior to her planned discharge.

3.25 A discharge plan was put in place, with the aim that Michael would be out of Jennifer's home. Jennifer's thoughts and feelings were not included within the discharge plan and Michael was not spoken to ahead of the discharge date.

3.26 Jennifer was found deceased in the hospital, 24 hours prior to her planned discharge.

4. Areas of focus

The learning group were asked to consider the below template against all the information provided and then feedback for a wider group discussion:

<table>
<tr><td colspan="3">Title:

Summary of relevance given, what happened up to this point:</td></tr>
<tr><td colspan="3">1. What needed to happen during this period? How do we know what 'good' looked like?</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="4">2. How does that compare to actually what happened?
• Where did reality exceed?
• What was needed?
• Where were there gaps?
• Where were the inadequacies?</td><td colspan="2">IN THE CASE: PAST</td></tr>
<tr><td>3. A)
How usual, standard, typical were the different aspects of the response at the time?</td><td>4. A)
What were the respective supports, constraints and barriers for different aspects?</td></tr>
<tr><td colspan="2">BEYOND THE CASE: PRESENT</td></tr>
<tr><td>3. B)
Would the response be likely now?</td><td>4. B)
Do these contributory factors still hold?</td></tr>
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4.1 Domestic Abuse, Mental Health and Suicide

4.1.1 It should never be underestimated the devastating impact domestic abuse has on a victim's mental wellbeing, and their ability to cope and manage day to day life. This is evidenced in the research by Howard et al. (2020) who said:

"The impact of domestic violence has been thought to have psychological parallels with the trauma of being taken hostage and subjected to torture".

4.1.2 Domestic abuse is complex and those who abuse use multiple behaviours to ensure they maintain power and control over those they are in a relationship with. For family, friends and professionals it can be challenging to identify the abuse, especially when there are other compounding factors such as mental health and suicidal ideation. For those subjected to abuse it can be terrifying, confusing, difficult to understand and ultimately dangerous to escape from.

4.1.3 Jennifer reported not only physical and sexual abuse from Michael but also indicated coercive and controlling behaviours[6] and economic abuse. Whilst Jennifer was alive, there was no statutory definition of domestic abuse, however, financial abuse was recognised as a behaviour of coercive control.

4.1.4 There was limited recognition within this case of the dynamics and risks associated with post-separation abuse, a form of continued coercive control that often escalates once a relationship ends. Separation does not equate to safety; in fact, it is widely recognised as a period of heightened risk for victims, particularly when the perpetrator seeks to reassert lost control through new and insidious tactics[7]. Coercive controlling behaviour does not stop when a relationship ends. The Domestic Abuse Act 2021 recognises this and on 5th April 2024 S76 Serious Crime Act was amended to include ex-intimate partners. In this case, Michael exploited Jennifer's mental health vulnerabilities to maintain dominance, refusing to leave her home, threatening to remove the children, blackmailing her emotionally, and contacting services to demand updates on her condition. These behaviours are consistent with known patterns of post-separation abuse, which can include legal harassment, economic manipulation, surveillance, and the weaponisation of children[8]. Such tactics are designed to destabilise the victim, undermine their credibility, and isolate them from support.

4.1.5 Jennifer did not have to be in Michael's presence for the abuse to continue. He was heard on several occasions when Jennifer had FaceTimed with the children. He would be in her home, shouting and swearing at her, on occasions making the children cry. Additionally, when Jennifer would not tell him who was taking her to her scheduled job interview, he started shouting and swearing at her. These incidents demonstrate how Michael's control extended beyond physical proximity; his presence loomed even when he was not directly involved in Jennifer's day-to-day life. His ability to intrude on moments intended for connection with her children and time to recover, and to provoke fear and distress through verbal aggression, reinforced a climate of intimidation and unpredictability. By demanding information about her movements and reacting with hostility when she asserted boundaries, Michael maintained psychological dominance and eroded Jennifer's sense of autonomy. This form of remote abuse, where the perpetrator manipulates, surveils, or intimidates from a distance, is a recognised tactic of coercive

[6] https://www.legislation.gov.uk/ukpga/2015/9/section/76/enacted
[7] https://www.tandfonline.com/doi/pdf/10.1080/26904586.2023.2177233
[8] https://getcourtready.co.uk/blog/understanding-post-separation-abuse-behaviours-tactics-and-personality-profiles

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control and harassment, and in Jennifer's case, it significantly heightened her fear while reinforcing Michael's power. It left her feeling constantly monitored, emotionally destabilised, and unable to reclaim safe space, even within her own home.

4.1.6 The MARAC in February 2020 identified this pattern of behaviour and Police recorded coercive control on their systems. However, other agencies such as Primary Care, Social Care and Education, did not appear to fully understand or respond to these behaviours as part of a broader pattern of coercive control. Instead, there was a tendency to view incidents in isolation, or to frame Jennifer's distress as a mental health issue rather than a trauma response to ongoing abuse. This highlights a critical need for professionals across safeguarding, health, and legal systems to be trained in recognising post-separation abuse and its impact, not only on the adult victim but also on any children involved.

4.1.7 Agencies involved did not appear to fully understand or respond to these behaviours as part of a broader pattern of coercive control. Instead, there was a tendency to view incidents in isolation, or to frame Jennifer's distress as a mental health issue rather than a trauma response to ongoing abuse. This highlights a critical need for professionals across safeguarding, health, and legal systems to be trained in recognising post-separation abuse and its impact, not only on the adult victim but also on any children involved. A coordinated, trauma-informed response is essential, one that does not rely on the victim to manage the risk alone, but instead proactively identifies patterns of control and intervenes to disrupt them.

4.1.8 The impact of the domestic abuse was significant to Jennifer's mental health. She openly shared that she felt that no one believed her, Michael was in control, he kept getting away with his abuse, felt hopeless which resulted in her struggling to engage with services as she feared the repercussions. Even though she made attempts to articulate her fears and the impact of the abuse, there continued to be an over-emphasis on Jennifer to take action with regards to keeping Michael away, rather than agencies understanding the context of how difficult life was for her.

4.1.9 In March 2020 a social worker and GP made statements: '*unless mum takes measures to ensure Michael stays away this will never be resolved*. *Her mental health impacts on her ability to do that and consequently he is likely to always be in her life'* (social worker) and '*She has gone back to the same environment despite divorcing her husband….she is currently in hospital but there is no reason for her to be there now, there is nothing else that can be done for her. It is very frustrating as Jennifer is very avoidant*' (GP).

4.1.10 This illustrates how victim-blaming language, and a limited understanding of coercive control can obscure the lived reality of domestic abuse and undermine effective safeguarding. The repeated emphasis on Jennifer's perceived failure to "*keep Michael away*" reflects a troubling shift of responsibility onto the victim, rather than recognising the structural and psychological barriers she faced. Statements such as "*unless mum takes measures to ensure Michael stays away this will never be resolved*" and references to Jennifer being "*very avoidant*" fail to acknowledge that Michael exercised near-total control over her life. These comments suggest a lack of professional curiosity about the mechanisms of coercive control: how fear, manipulation, dependency, and trauma can erode a person's autonomy and capacity to act. Even with these fears, Jennifer had made steps to try and 'keep Michael away' by exploring a non-molestation order; she had tried

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to get him to leave but was fearful of the repercussions, especially that Michael would turn the children against her.

4.1.11 Moreover, the GP's assertion that "*there is nothing else that can be done for her*" signals a sense of professional helplessness that risks abandoning Jennifer rather than adapting support to her circumstances. This language not only reinforces shame and isolation but also risks legitimising the perpetrator's control by framing the victim as complicit in her own harm.

4.1.12 Jennifer demonstrated consistent engagement with mental health services, actively seeking support from both the community mental health team and hospital professionals. Her actions reflected an acute awareness of her own mental health decline: she not only recognised the need for intervention but courageously acted on that insight, even in the context of self-harm and persistent suicidal ideation. This help-seeking behaviour represents a strong protective factor, often associated with resilience and an intention to survive. However, despite Jennifer's proactive efforts to access appropriate care, it became evident that Michael exploited this vulnerability. He used her disclosures of distress and diagnoses as tools of control, undermining her credibility with professionals, portraying her as unstable, and weaponising her mental health needs in interpersonal dynamics to shame, disempower, and isolate her further. This manipulation compounded Jennifer's psychological distress and may have increased barriers to safety by distorting professionals' perceptions and limiting the effectiveness of external support. It also reflects a wider systemic issue as failure to do so can result in devastating consequences.

4.1.13 Jennifer's repeated suicide attempts, alongside her openness about researching and planning her death, must be understood not simply as a manifestation of mental illness, but as a response to sustained trauma and coercive control. Her experience reflects a deeply troubling and often overlooked reality: that the psychological toll of domestic abuse can be just as lethal as physical violence. Recent data[9] confirms that more victims of domestic abuse now die by suicide than by homicide, with an estimated 10 women a week dying by suicide and at least 30 attempting to take their own lives. These figures are not abstract; they represent women like Jennifer, whose sense of entrapment, hopelessness, and fear became overwhelming[10].

4.1.14 The Suicide Timeline by Jane Monkton-Smith outlines 8 stages to assess a victim's risk when there are thoughts of suicide. These are:

1. ***The perpetrator has a history of abuse:*** We have no record that Michael had been abusive to previous victims, however, Jennifer alleged he had been abusive throughout their 19-year marriage and 3-year separation.
2. ***The relationship starts quickly or intensely:*** Jennifer met Michael at the age of 18 and had a child 18 months later. The military are known for 'shotgun weddings[11]' (military people have very rushed relationships) due to the housing entitlement.
3. ***There is a relationship dominated by control:*** Jennifer disclosed Michael had been controlling throughout their marriage, including sexual and economic abuse.
4. ***The victim starts to disclose as they become more distressed by the abuse or violence:*** Jennifer made brave steps to leave the marriage and try to escape Michael.

[9] https://safelives.org.uk/news-views/domestic-abuse-and-suicide-figures/
[10] https://prevent-suicide.org.uk/blog/suicide-prevention-and-domestic-abuse-a-critical-link-that-professionals-must-address/
[11] The military use this term where couples marry quickly due to deployment, housing or other pressing circumstances. https://www.theknot.com/content/shotgun-wedding-meaning

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However, he continued to manipulate her, their children and others to continue to abuse her. She shared a sense of hopelessness and continued abuse from Michael.

5. ***The victim starts to actively seek help from agencies like the Police, Mental Health services, GPs or IDVAs:*** Although Jennifer struggled to engage with services, she disclosed abuse to Police, social care, mental health services, GDASS and Stroud Beresford Group.
6. ***The victim starts talking about ending their life as the abuse is persistent and intense:*** Jennifer self-harmed with deep cuts which escalated to overdoses. She went on to share how she was researching how to take her own life and had chosen a method.
7. ***The victim says they feel completely trapped by the perpetrator and will never be free:*** Jennifer voiced that she would never be free from Michael even though they were divorced, she felt as if she had lost control of her children, her home and her life.
8. ***There is a suicide:*** Jennifer took her own life.

4.1.15 Jennifer had told agencies she was suicidal, and although many agencies were aware of the risks of homicide to victims of domestic abuse, there was little education (at the time) of the risks around suicide. Jennifer was also demonstrating the 3 steps of suicide:

- ***Stage 1 - The "ideation" stage;*** *During this stage, the person who takes their lives will consider the consequences and be unsure of whether they will go ahead.* Jennifer tells her mental health worker that she did not feel she could continue to live. Although she was devoted to her children and there were never any concerns raised around her care for her children, she told her care coordinator that Michael had a negative influence on them and she did not want to be alive to witness this evolve, feeling suicide was her only option.
- ***Stage 2 – The "planning" stage;*** *The person feels compelled to plan suicide (thus moving into Stage 3) or not to at that time; a decision that most people do not discuss with loved ones and often wrestle with in isolation.* Jennifer told the hospital staff that she had been researching how to take her own life and purchased the sodium nitrate to carry it out. She was also found in the early hours of the morning and therefore chose overnight or at staff handover to act upon her thoughts.
- ***Stage 3 - The decision to suicide;*** *The moment the decision is made, it goes "unconscious", and the person goes on "auto-pilot." People in Stage 3 are imminently lethal; however, they seem more "normal" than they have seemed in a long time. At this point, the depression seems to suddenly lift because the person has made the decision to die and is no longer wrestling with the decision. Unfortunately, most mental health professionals and family members are not trained to recognise "auto-pilot," as the patient seems so much better, not realizing they will take their own life. People on "auto-pilot" typically attempt suicide within the next 48 hours*. No one knows what happened in the last few hours of Jennifer's life, however, at the final moments of her life she made the decision that to die was the only option for her.

4.1.16 The Government Suicide Strategy 2023 – 2028[12] recognises that although there is ongoing work across government to address different presenting factors with regards to suicide, there are some specific factors (many of which are linked to these wider determinants) to be addressed as a priority, one of which is domestic abuse. The strategy suggests local suicide prevention and domestic abuse strategies work together to ensure a coordinated and collaborative approach to victims and perpetrators who are at high risk of harming themselves.

[12] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028

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4.1.17 Gloucestershire has a Domestic Abuse Strategy and Suicide Prevention Strategy; however, these do not interlink or support each other. In addition, training for those who are working with victims of domestic abuse needs to highlight the significant risk domestic abuse has on a victim's suicidal ideation. This will hopefully enable supportive action plans but also evidence the significant adverse effect the abuse has had on the victim.

4.1.18 This review demonstrates the devastating cumulative impact of coercive control, psychological abuse, and unaddressed trauma on an individual already struggling with mental health challenges. In Jennifer's case, the lack of sustained, coordinated, and trauma-informed intervention allowed cycles of abuse and emotional deterioration to continue unchecked. Her repeated attempts to take her own life were not isolated crises, but clear signals of despair linked to an environment where she felt trapped, disbelieved, and unsupported. Suicide in the context of domestic abuse is a safeguarding issue. It demands that professionals move beyond incident-based responses and instead adopt a whole-system, relationship-aware lens, one that recognises suicidal ideation as both a mental health concern and a consequence of prolonged victimisation. The system must hold space for complexity, understanding that recovery and safety are not linear, and that victims of coercive control often need persistent, wraparound support to rebuild autonomy and hope. Without this shift, the cost is not only a failure of services but a loss of life that might have been prevented.

4.1.19 A trauma-informed approach is essential as it does not rely on the victim to manage the risk alone, but instead proactively identifies patterns of control and intervenes to disrupt them. Agencies would have recognised Jennifer's behaviour as a survival response, not a failure of engagement, and would have focused on reducing risk through coordinated, compassionate intervention rather than conditional support.

4.1.20 Jennifer's case should have been identified in 2020 for a review, and this was an opportunity missed to have explored the case years ago. It is therefore essential that Gloucestershire improves identification and recording of abuse-linked suicidality. Coroners, police, and health professionals should be supported to identify and record when suicide is linked to domestic abuse. This data is essential for prevention and learning.

4.2 Multi-Agency Safeguarding and Decision Making

4.2.1 There were multiple agencies involved with Jennifer, all actively sharing information and making referrals to safeguard both her and the children. Notable examples of effective multi-agency practice included collaboration between Stroud Beresford Group and the mental health support worker, who communicated concerns and ensured that each service remained informed of Jennifer's care plans. In addition, Child in Need, Strategy, and Team Around the Family meetings played a key role in keeping the children's welfare at the forefront of professional decision-making.

4.2.2 There were, however, clear opportunities that were missed at the time; though it is noted that practice has since improved to prevent recurrence. Jennifer was referred to MARAC on two occasions but was not discussed at either meeting. The first referral, in 2017 following alleged rape and assault, was screened out on the basis that she was engaging with GDASS and had been placed in emergency accommodation by housing services. The second referral was made in early February 2020 by Stroud Beresford Group in response

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to escalating concerns. However, this was not reviewed until three weeks later (the day of Jennifer's death), when the MARAC decision-maker concluded that the case did not meet the threshold, as Jennifer was in hospital and therefore the risks were believed to be reduced. This decision included a recommendation for a discharge planning meeting (even though this had already occurred).

4.2.3 These decisions were not appropriate, as both rape and suicidal ideation linked to domestic abuse represent clear high-risk indicators. Being in hospital should not have been viewed as a resolution to risk, particularly as Jennifer would not have remained in hospital indefinitely. The MARAC process represented a missed opportunity to share critical information and develop a robust multi-agency safety plan both during Jennifer's hospitalisation and in preparation for discharge. It also could have provided a mechanism to consider safe and coordinated engagement with Michael to disrupt his harmful behaviours and better protect Jennifer.

4.2.4 A Team Around the Family meeting was held at one of the children's schools just five days before Jennifer's death. In attendance were Social Care, the Mental Health Crisis Team, the GP, and the school. Apologies were received from the other school and GDASS, but notably absent were key agencies: Stroud Beresford Group (who had recently referred to MARAC), the Police (who had recorded a recent coercive control crime), and the military, who were actively involved with Michael. Records from the meeting noted that "*she may commit suicide*", yet no clear actions were agreed on to address this risk or explore its underlying causes. The discussion reflected a limited understanding of coercive control, describing Jennifer as "*accepting of a controlling relationship*" without unpacking the context or impact. In the absence of a domestic abuse specialist, minimising language went unchallenged, and Jennifer's behaviour was pathologised rather than supported.

4.2.5 The discharge plan stated Michael would be "asked" to leave Jennifer's home; it failed to reflect her legal right to safety or the gravity of her fears. It also omitted Jennifer's voice entirely: her wishes, feelings, and need for reassurance were not documented or acted upon. It also failed to consider options in disrupting Michael's behaviour and challenging his continued controlling behaviour. This meeting was ineffective with multiple agencies not attending, it had a poor understanding of the complex dynamics of domestic abuse within the military and used passive language. As a result, the lack of coordination meant that the safety plan neither protected nor empowered Jennifer or the children.

4.2.6 In February and March 2020 (whilst Jennifer was in hospital), hospitals were being instructed by the Government to plan and vacate hospitals due to the COVID-19 pandemic and upcoming lockdowns. All NHS Foundation Trusts were instructed to discharge patients who did not require hospital admission; although it is not recorded within Jennifer's notes it is possible that although Jennifer's risk to herself remained high, with the pressure to make beds available and demands on the services, Jennifer's discharge was fast tracked.

4.2.7 Jennifer's case highlights significant systemic shortcomings in the safeguarding response within a military context. Despite the gravity of the allegations (rape and assault), for which Michael was arrested and bailed, referrals to MARAC, coercive control, self-harm and suicide attempts, there was a lack of coordinated information sharing between civilian safeguarding agencies and the military. The Army was not informed of the MARAC, DASH, or the outcomes of professional meetings held by Children's Social Care, limiting their ability to assess risk or implement protective measures.

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4.2.8 Despite multiple agencies being involved, including Social Care, schools, primary care and mental health services, there is no evidence that a DASH risk assessment was completed, other than by Police and domestic abuse services. The DASH is a nationally recognised tool used to identify the level and nature of risk to victims and their children, providing a consistent framework for decision-making and access to specialist support pathways. Its omission in this case is significant. Without a completed DASH, and with professionals relying on assumptions that other agencies had undertaken this task, there was a risk that escalating harm, patterns of coercive control, and new safeguarding concerns went unrecognised. This reliance on informal risk perceptions, rather than a structured assessment, contributed to a false sense of security that appropriate action was already underway.

4.2.9 Best practice dictates that a DASH should be completed or reviewed whenever a new disclosure or referral is received, regardless of which agency is leading. This ensures risks are actively identified, updated, and shared, creating a dynamic picture of the victim's experience and facilitating a proportionate safeguarding response. In this case, the absence of such a process reflects not only a missed opportunity to assess the true level of risk faced by Jennifer and her children, but also a breakdown in coordinated safeguarding practice.

4.2.10 The insidious impact of domestic abuse demands serious attention across all safeguarding systems. Suicide risk must be recognised as a direct consequence of abuse, not merely a co-occurring mental health issue. In Jennifer's case, the abuse she endured, combined with the lack of sustained, trauma-informed intervention left her increasingly isolated and emotionally depleted. She had clearly stated at the start of March 2020 to her care coordinator that she felt she had to tolerate Michael's abuse and her only option upon discharge was suicide. However, this concern and risk was not mitigated by the discharge plan.

4.2.11 Agencies must be equipped to identify the signs of psychological abuse; its impact and how this can increase the risk of suicidal ideation. If this occurs, it will enhance a joined-up safeguarding response, ensuring that victims are met with empathy, not judgment, and that risk is assessed holistically. Without this shift, too many women will continue to suffer in silence, and too many lives will be lost to preventable harm.

4.3 Impacts on children and family

4.3.1 The presence of domestic abuse within a household has far-reaching consequences, not only for the immediate victim but also for any children connected to the environment. While the primary focus may centre around the adult victim, the analysis must also acknowledge the profound and often less visible impact on children's emotional, psychological, and developmental wellbeing. Exposure to coercive control, intimidation, or violence, whether directly experienced or witnessed, can shape a child's sense of safety, attachment, and resilience. Although there were Child in Need and Team Around the Family meetings, these mainly focused on the risks and impact of Jennifer's mental health rather than the domestic abuse. The absence of consistent multi-agency recognition of these additional risks raises critical questions about how effectively services are identifying, recording, and responding to the safeguarding needs of children living in contexts of domestic abuse. This section explores the implications for practice and highlights the importance of adopting a whole-family, trauma-informed approach to intervention and protection.

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4.3.2 The decision by Children Social Care to close the case in 2017 on the basis that the children were "safe" due to attending boarding school reflects a narrow understanding of risk. Jennifer's disclosure that the abuse from Michael escalated when the children returned home should have triggered a more robust safeguarding response, recognising that children remained at risk during contact periods, holidays, and even through indirect exposure to coercive control or emotional harm. The closure missed an opportunity to assess the broader context of domestic abuse and its cyclical nature, particularly how perpetrators may intensify control when family dynamics shift.

4.3.3 Under current safeguarding expectations, such a disclosure would warrant a multi-agency risk assessment, consideration of protective measures during home visits, and ongoing monitoring of the children's emotional wellbeing. It would also be expected that Children's Social Care would liaise with the boarding school to ensure staff were alert to signs of distress or disclosure, and that the case would remain open until a comprehensive understanding of the children's lived experience (both at school and at home) had been established. This case highlights the importance of recognising that physical separation does not equate to emotional or psychological safety, and that safeguarding responses must be dynamic, contextual, and trauma informed.

4.3.4 Interaction with the state schools and wider services appeared to improve once the children transitioned into the state education system. One of the schools raised concerns about persistent absences and the reasons provided by Jennifer and Michael, which were shared with Children's Social Care through the Team Around the Family process. However, it is unclear whether the school was ever made aware of the family's history of domestic abuse; instead, concerns remained focused primarily on Jennifer's mental health and its impact on the children. While the school acted proactively by alerting the social worker when one of the children wrote a story that suggested domestic abuse within the home, there is no evidence that this disclosure was followed up by Children's Social Care, nor that the child was offered any support by the school. Had the school been fully informed about the domestic abuse history, it might have better understood the significance of the child's story and been more equipped to provide trauma-informed support.

4.3.5 That said, once Jennifer was in hospital in March 2020 the school spoke to the child about the story and how powerful this was and offered them a thoughts and feelings diary. They also reassured the child that it would be up to them if they shared this: the child agreed to this. This highlights the critical importance of robust information sharing between agencies so that early signs of distress are not overlooked, and children receive the timely emotional support and safeguarding interventions they need.

4.3.6 The continued presence of coercive control and emotional abuse within the home had a profound and destabilising impact on both Jennifer and her children. Despite periods of perceived calm when Michael was present, the evidence paints a picture of a highly volatile environment shaped by manipulation, fear, and emotional inconsistency. Jennifer's deteriorating mental health, compounded by domestic abuse, had visible repercussions for the children, who exhibited signs of emotional distress and behavioural challenges. Interactions noted by professionals, including Jennifer's report that Michael had previously attempted to kill her in the presence of the children, alongside Michael's aggressive demeanour witnessed by mental health staff, indicate a pattern of power and control that permeated daily life.

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4.3.7 The children's conflicting behaviours, such as idolising their father while also showing distress and checking Jennifer's phone in his absence, suggest a heightened level of emotional vigilance and adaptation to adult dynamics, often seen in households affected by coercive control. Michael's dismissive and demeaning comments during Crisis Resolution and Home Treatment Team (CRHTT) contact further demonstrate his minimisation of Jennifer's mental health and emotional needs, creating an unsafe and invalidating atmosphere for all family members.

4.3.8 Coercive control distorts family dynamics; Michael's behaviour created an environment of fear, emotional instability, and confusion. The children adapted to this by monitoring Jennifer's behaviour and internalising conflicting loyalties, which is a hallmark of trauma in coercively controlled households. Children are not passive witnesses: the emotional distress, behavioural changes, and conflicting narratives from the children demonstrate that they were directly affected by the abuse. Their experiences should have been recognised as safeguarding concerns much earlier in any intervention. This leads onto the minimisation of risk due to Michael's presence; professionals appeared to interpret his presence as stabilising, despite evidence of controlling and emotionally abusive behaviour. This reflects a need for greater professional curiosity and understanding of how coercive control can mask as "protective" parenting.

4.3.9 An example of this was when the social worker saw the two youngest children at home with Michael. They were not seen or spoken to alone as the main purpose of the visit was to see and speak with Michael. Michael spoke of his military background and the conversation largely centred around Jennifer's mental health and how Michael saw himself as someone who was helping/supporting and that she could not cope without him there. He also shared that he did not have a home and had not been invited to stay in Jennifer's home. During this meeting he was presenting as the saviour, looking after the children and Jennifer. At no stage is he told he should move out and it is not his home, and he dominates the conversation about himself and the positive actions he was making.

4.3.10 These dynamics underscore the importance of recognising domestic abuse as a form of harm with wide-reaching effects, and the critical need for practitioners to assess not only direct risk of physical harm, but also the ongoing emotional and psychological toll on children who live within coercively controlled environments.

4.3.11 Since Jennifer's death, the Domestic Abuse Act 2021 has been introduced, which created not only a definition of domestic abuse but also identified that children are victims of domestic abuse and not 'just' witnesses, ensuring they receive the same support as the immediate victim. Training has been developed across all partners who took part in the learning event to upskill agencies in recognising signs and equip practitioners in how to respond to victims and those who cause harm. That said, there is still further work that can take place; all services need to ensure children's voices are central in domestic abuse cases, whether disclosures are verbal, behavioural or creative, they must be taken seriously and followed up. Schools, mental health services and social care must work collaboratively to build a full picture of the child's lived experience. This includes sharing relevant history (e.g. domestic abuse), ensuring safeguarding responses are not siloed or overly focused on one parent's mental health.

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4.4 Military Community

4.4.1 The military community has emerged as a critical area of focus within this review due to its unique structural, cultural, and safeguarding complexities. Military life often operates within a semi-closed system, where allegiance, hierarchy, and institutional identity can unintentionally obscure or complicate responses to domestic abuse. Spouses and partners of serving personnel may experience heightened isolation, limited access to independent support services, and significant fear about the consequences of disclosure (both for their own wellbeing and their partner's career).

4.4.2 These dynamics, combined with frequent relocations and financial dependency tied to military benefits, can create an environment where victims are less visible to mainstream safeguarding systems. In this case, the tragic death of a military wife and the subsequent safeguarding concerns highlighted systemic gaps in information sharing, professional boundaries, and victim engagement, underlining the urgent need for tailored safeguarding approaches that recognise the lived realities of those within the armed forces community.

4.4.3 It appears the military community impacted the family's life. The children attended boarding school which incurred debt, and Michael was a high-ranking officer which created a barrier and fear for Jennifer. She believed the response to her was impacted due to him outranking the welfare officer, therefore creating mistrust and suspicion. Those within the military remain a hidden community and this may have impacted on Jennifer and the children, including her feeling able to escape him.

4.4.4 The role of an army officer's wife is often steeped in unspoken expectations, for example: gracefully hosting formal events; upholding an image of resilience and loyalty; and managing the domestic front largely on her own during extended postings or deployments. She may be expected to offer unwavering emotional support to her partner, embody composure under pressure, and integrate seamlessly into the structured, often hierarchical social world of military life. While some find pride and purpose in this role, the weight of these assumptions and expectations, particularly when combined with isolation, frequent relocation, and the constant undercurrent of worry, can place immense pressure on the wife's sense of identity, autonomy, and mental wellbeing. The emotional labour required is seldom acknowledged, yet it quietly sustains the complex ecosystem surrounding military service.

4.4.5 When allegations of domestic abuse are made against a serving army soldier (especially an officer), with the additional public or documented concerns about their partner's mental health, there can be significant and complex implications for their professional standing, both formally and informally.

4.4.6 Within military communities, there can be a strong culture of silence around domestic abuse. Spouses may fear that reporting abuse could damage their partner's career or lead to loss of housing and financial security. There is a handbook for those who are victims of domestic abuse which provides information of welfare services, legal options and tools and support around safety[13]. Even though this is available, there continues to be hurdles for those within the military to seek help and support.

[13] https://www.gov.uk/government/publications/armed-forces-domestic-abuse-a-handbook-for-civilian-support-services/armed-forces-domestic-abuse-a-handbook-for-civilian-support-services

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4.4.7 As in Michael's case, there were formal consequences after he was arrested for rape and assault. Jennifer would have been aware of these consequences, which may have increased her concern of further repercussions should she make further allegations. The military take allegations of domestic abuse seriously, with clear guidelines for the Military Police and Welfare Service[14]. Even though the rape and threats to kill allegations were being dealt with by Gloucestershire Police, a proactive response was swiftly made by the army. However, the Military Police were never informed of the arrest or other concerns which would be expected now with new information sharing processes.

4.4.8 The impact on Michael's career could have been significant, especially with the severity of the allegations made, as they may have impacted security clearance and eligibility for promotion, as domestic abuse is considered incompatible with military values and operational readiness. Additionally, the allegations could have affected Michael's reputation within the tightly knit military environment, where personal and professional lives are deeply intertwined. These risk, therefore, provided him with further justification to control the narrative to professionals and continue to exert his dominance over Jennifer.

4.4.9 Jennifer's declining mental health may have impacted how her allegations were perceived. During his discussions with the welfare officer, he would often blame Jennifer's mental health or the stress that he was under. His minimisation of his actions continued throughout his interactions with the welfare service, even though he agreed to work with SPLITZ. Research (from the USA) found that military wives face several obstacles when seeking support for their mental health. This included stigma of mental health within the armed forces, concerns for the partner's career, impact on the children and balancing self-care with family responsibilities. These challenges, along with domestic abuse indicate that it is not surprising Jennifer was struggling to manage life[15][16].

4.4.10 The Army Welfare Officer provided support to both the alleged perpetrator and the victim, a dual role that is widely recognised as inappropriate in domestic abuse cases and risks undermining the victim's safety and trust in the system. This would not happen now and occurred during this time due to limited staff available. Jennifer raised her concerns regarding the welfare officer to her support worker, stating she felt Michael had a superiority over the welfare officer due to rank and therefore did not feel she would be believed. Even with this perception, the welfare officer made repeated attempts to engage with both. Even though they struggled to speak to Jennifer, however, they were proactive in seeking solutions for Michael. The military has a responsibility to safeguard both the alleged victim and the accused, and it is apparent they made attempts to do this. Since this time, domestic abuse cases are now held with the Military Public Protection Unit who attend all MARACs and safeguarding. Therefore, the response Jennifer received in 2020 would not occur now.

4.4.11 The British Armed Forces have trained military police and welfare officers with the SafeLives DA Matters, to enhance officers' understanding of domestic abuse (especially coercive control) and support them in their response to victims and those who use abusive behaviours. Additionally, if a serving member gets arrested within their own locality, the military police will be made aware by the local constabulary. An internal

[14] https://centreformilitaryjustice.org.uk/guide/domestic-violence-in-the-armed-forces/
[15] https://military.healthywomen.org/military-stress-impacts-the-mental-health-of-military-spouses-heres-how-they-cope/
[16] https://neurolaunch.com/military-wife-depression/

report is created, and information is sought from the local constabulary regarding MARAC and safeguarding measures to ensure information is shared.

4.4.12 This case underscores the unique vulnerabilities of military spouses, who often form a hidden community within safeguarding systems. Barriers such as fear of reputational damage to the serving partner, economic dependence linked to military benefits and housing, social isolation due to frequent relocations, and a lack of clarity around reporting pathways can all deter victims from seeking help[17]. These dynamics demand a more robust, trauma-informed, and military-aware safeguarding approach, that ensures clear information sharing protocols, role clarity for welfare staff, and proactive outreach to those who may be suffering in silence behind the closed doors of military accommodation[18].

5. Recommendations

5.1 Recommendation 1

Safeguarding partnerships are to ensure that all relevant agencies, including police, domestic abuse services, military welfare (where applicable) and specialist services, are invited and expected to attend key meetings such as Strategy meetings, MARAC, TAF, and discharge planning.

5.2 Recommendation 2

Training available via the GDASS pathway to ensure it integrates trauma-informed practice, victim-centred practice with dynamic risk assessment. This training should equip staff to move beyond assumptions, recognise substance use and mental health as potential consequences of abuse, and respond with compassion, clarity, and accountability.

5.3 Recommendation 3

Strategies and policies are to recognise suicide as a safeguarding issue where domestic abuse is present.

5.4 Recommendation 4

Safeguarding partnerships are to regularly audit multi-agency meetings and decision-making processes to identify patterns of exclusion, missed risk, or ineffective planning and use findings to drive continuous improvement.

5.5 Recommendation 5

Gloucestershire Constabulary to develop clear information sharing protocols to ensure they share the DASH with the Military Police.

5.6 Recommendation 6

Domestic Abuse training for both civilian and military professionals is to be reviewed to ensure it highlights specific risks, barriers, and cultural dynamics affecting military families.

[17] https://www.gov.uk/government/publications/support-within-the-foreign-and-commonwealth-community-for-those-affected-by-domestic-abuse/barriers-faced-by-the-military-community-affected-by-domestic-abuse

[18] https://www.fim-trust.org/wp-content/uploads/domestic-violence-abuse-military-families-improving-signposting-specialist-support.pdf

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5.7 **Recommendation 7**

To create a collaborative response to victims, children and those who cause harm, a military representative should be included within the local safeguarding partnership boards and strategies.

6. Conclusion

6.1 Jennifer's death is a deeply tragic reminder of the enduring impact of domestic abuse, not only during a relationship, but long after separation. Despite being divorced from Michael, the abuse continued, compounding the emotional toll and intersecting with the unique pressures of military community life. This review has highlighted how coercive control, trauma, and systemic gaps in understanding can converge to leave victims isolated and unsupported.

6.2 Jennifer was a mother, a member of a community, and a person deserving of safety, dignity, and care. Her experience underscores the urgent need for services to recognise the long-term psychological effects of abuse, to respond with trauma-informed and victim-centred practice, and to challenge assumptions that may obscure risk.

6.3 We must learn from Jennifer's story, not only to honour her life, but to ensure that others in similar circumstances are seen, heard, and protected. This review calls for renewed commitment to professional curiosity, empathetic safeguarding, and collaborative action across agencies. Only through such learning can we hope to prevent future tragedies and uphold our collective responsibility to those affected by domestic abuse.

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Appendix 1 – Glossary

Acronym	Description
DARDR	Domestic Abuse Related Death Review
DASH RIC	Domestic Abuse Stalking and Honour based abuse Rick Indicator Checklist provides agencies a consistent tool to evaluate risk and make appropriate referrals.
GDASS	Gloucestershire Domestic Abuse Support Service (?)
GP	General Practitioner – Provide community medical care
GRASAC	Gloucestershire Rape and Sexual Assault Centre
MARAC	Multi-Agency Risk Assessment Conference discusses high-risk cases of domestic abuse.

Appendix 2 – Panel members

Agency	Role and department
British Army	Army Welfare Military Police – Public Protection Unit
Bielec Consultancy Ltd	Chair and Author
Gloucestershire Constabulary	VAWG Policy and Strategy Lead VAWG Research Officer
Gloucestershire County Council	Children Social Care
GDASS	Service manager
Gloucestershire Health and Care NHS Foundation Trust	Safeguarding Lead
GRASSAC	Service Manager
NHS Gloucestershire Integrated Care Board	Safeguarding and Domestic Abuse Lead
Stroud Beresford Group	Adult Safeguarding Lead
Stroud Community Safey Partnership	Domestic Abuse Lead
Safer Gloucestershire	Service Manager

Appendix 3 – Agencies providing a review

- Children's schools
- Children Social Care
- Gloucestershire Constabulary
- GDASS
- Gloucestershire Health and Care NHS Foundation Trust
- GRASAC
- MARAC
- Phoenix Health Group
- Stroud Beresford Group

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