Gloucestershire

Domestic Abuse Related Death (Rapid) Review

Diane died in May 2024

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Pen Portrait[1]

Diane was 63 years old when she died. She was a mother, grandmother, sister and woman with relationships, memories and experiences that went far beyond the information held in agency records.

Diane had people in her life who cared about her, including members of her family. She also lived with her dog and parrot, who appeared to be important to her. At different points, Diane spoke about wanting things to be different and accepted support that might help her regain some stability and independence.

Although Diane faced significant challenges in her life, she should be remembered as a person first and not by the difficulties she experienced. She was a woman whose life had meaning, connections and value. This review seeks to honour Diane's memory by learning from her experiences and improving responses for others in the future.

Preface

Safer Gloucestershire, the panel, and the author extend their deepest condolences to Diane's family. This review was conducted openly and constructively, with positive agency engagement enabling meaningful reflection on the circumstances of Diane's death and candid exploration of any issues raised.

1. Introduction

1.1 In May 2024, Diane a 63-year-old woman, died as a result of pneumonia whilst a resident in Stroud, Gloucestershire. The decision to commission a DARDR before Diane's cause of death was agreed, however, after the inquest it was determined the case did not fully meet the statutory criteria. It was identified that learning could be taken from Diane's circumstances, therefore, the Home Office agreed to this being a Rapid Review ensuring the Home Office Statutory Guidance 2016[2] was used.

1.2 The Home Office Multi-Agency Statutory Guidance for Domestic Homicide Review 2016, Domestic Violence, Crime and Victims Act 2004[3] and Social Care Institute for Excellence's (SCIE) 'Reviews in Rapid Time' (SARiRT)[4] guidance and templates were

[1] As Diane's family were not contacted as part of this review, this pen portrait is necessarily limited and drawn from the information available within agency records.
[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[3] https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004
[4] https://www.scie.org.uk/safeguarding/adults/reviews/in-rapid-time/

collectively used to support this process. 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 circumstances of Diane's death, a decision was made not to contact her family as the case was not being considered formally as a DARDR given the cause of death. 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 Diane, Larry or Diane's 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 **XX** 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. Equality and diversity considerations

2.1 Diane was a 63-year-old woman at the time of her death. Her age is relevant to this review because she was experiencing declining physical health, reduced mobility, increasing reliance on others, and possible barriers to independence. Although 63 is not generally considered old age, Diane's circumstances meant she may have experienced some of the vulnerabilities more commonly associated with older adults, including isolation, deteriorating health, difficulty accessing services, and increased dependence on others for practical support.

2.2 Diane's sex is also relevant. Domestic abuse disproportionately affects women and is often rooted in gendered patterns of power, control and inequality. Diane's experiences included allegations and indicators of coercive control, sexual abuse, emotional abuse, financial dependence and physical harm. Her presentation should therefore be understood within the wider context of women's experiences of domestic abuse, including the shame, fear, minimisation and self-blame that can affect disclosure and engagement with services.

2.3 Diane's alcohol dependency was another important equality and diversity consideration. Addiction can carry significant stigma, and there is a risk that professionals may consciously or unconsciously view alcohol use as a lifestyle choice rather than as a health condition, coping strategy, trauma response, or vulnerability that may be exploited by others. For Diane, alcohol use appears to have intersected with trauma, mental health, domestic abuse and self-neglect. This increased her vulnerability and may have affected how she was perceived, assessed and supported by agencies.

2.4 There is a well-recognised link between domestic abuse and substance use. Victims may use alcohol or drugs to cope with trauma, fear, anxiety, isolation or the impact of abuse. Perpetrators may also use a victim's substance dependency as a means of control, for

example by restricting access to alcohol, supplying it, humiliating the victim, undermining their credibility, or using it to suggest they are unreliable or responsible for the abuse

3. Key Episodes

Diane's background

3.1 Diane has 4 siblings with whom she had some contact with prior to her death. There is no information on Diane's childhood, however, she had disclosed to agencies that she had been subjected to childhood sexual abuse whilst in foster care and then sexual abuse as an adult (Diane stated this was not by Larry).

3.2 Diane and Larry were married (It is unclear for how long) but they had separated at the time of her death. Diane has one daughter (an adult) and one grandchild, with whom she had intermittent contact.

3.3 In 2017 Diane shared with mental health services that she had previously received private counselling and had experienced depressive and anxiety symptoms since 2015.

2019

3.4 In February, Diane took an overdose and told paramedics she did not want to wake up. She did not require hospital admission, and her daughter was contacted. Shortly afterwards, Diane's daughter informed GHC and Gloucestershire Constabulary that Larry was preventing her access to the property to collect Diane's belongings, as Diane was planning to stay with her daughter to address her alcohol use. When police attended, they were advised that Diane and Larry had separated the previous day. Diane's daughter expressed concerns about emotional and physical abuse by Larry, which Diane did not confirm.

3.5 In October, Diane's daughter reported to Gloucestershire Constabulary that Larry had raped Diane three times and subjected her to coercive control during a 2016 holiday. She alleged hearing Diane say "No get off me" during sex but did not intervene due to fear of Larry. When questioned, Diane denied the incident. Diane's daughter also claimed to have seen messages suggesting Diane had sex with other men at Larry's behest, and that Diane had disclosed Larry controlled her finances and exploited her alcoholism for sex. The report was referred to CID. Diane was interviewed by officers with the support of Change, Grow, Live (CGL - the Gloucestershire's Drugs and Alcohol service at the time), denying coercive or controlling behaviour (aside from name calling) and stating all sexual activity was consensual. She described her daughter's allegations as malicious. With no supporting evidence, no further action was taken.

2020

3.6 At the end of June, CGL referred Diane to MARAC with concerns around abuse and Diane wanting to leave the relationship. Within the referral it stated that Diane had mentioned the allegations her daughter had raised in 2019, but no detail was provided.

3.7 At the beginning of July, Diane called 999 stating "*Domestic Abuse, just get here*." When officers arrived, Larry was waiting outside, and Diane was in the bedroom. She alleged

Larry had called her a "*Fat Bitch*" and taken a bottle of wine. No offences were identified, and support service details were provided.

3.8 The following day, GDASS spoke with Diane's daughter and supplied documents to help secure safe accommodation. Diane was discussed at MARAC in her daughter's local area (after Gloucestershire Constabulary completed a MARAC-to-MARAC transfer) with no actions were identified.

3.9 In early September, Diane's daughter contacted her local police force, reporting that Diane had returned to Larry 2 weeks earlier and she believed Diane was being abused. The referral was passed to Gloucestershire Constabulary for a welfare check. Officers found Diane with black eyes and a mark on her nose; she claimed she had tripped over the dog. Although officers were concerned, Diane insisted her daughter's allegations were malicious and asked to be left alone. She described feeling isolated from family due to their dislike of Larry, disclosed a six-year history of depression, and said Larry had strangled and pushed her 6 years ago but there had been no further physical violence. She was not working but said Larry gave her money when needed. Larry later reported that police had asked leading questions and that Diane's daughter was harassing them.

3.10 The incident was escalated to high risk and an IDVA liaised with CGL for contact details. When they spoke to Diane on the phone, she told them she was fine and wanted the Police to leave her alone. It became apparent the call was on loudspeaker and Larry was in the background. The call was ended and a request made of an urgent MARAC.

3.11 At the end of September, Larry contacted GHC expressing concern for Diane, stating she was intoxicated and suicidal when he returned home from work (as a taxi driver). He reported Diane drank daily and her support from CGL had declined due to COVID-19. He was advised to encourage Diane to contact the service. Larry also said tensions with Diane's daughter had worsened since an argument three years earlier, and that she had called police nine times alleging abuse, which he denied.

3.12 In early November, CGL submitted a MARAC update indicating ongoing abuse. Diane told the IDVA she wished to go to refuge in North Wales, but a discussion between the IDVA, CGL, and the refuge revealed limited availability due to her alcohol dependence. 5 days later, Diane told the IDVA she wanted to focus on her alcohol use and declined further support from GDASS, requesting no further contact. CGL was informed.

2021

3.13 In mid-April, Larry called an ambulance after Diane took a deliberate overdose while intoxicated. In A&E, Diane disclosed abuse from Larry and said her alcohol use had increased over the past two years. During a ward assessment by the Mental Health Liaison Team, she described struggling with estrangement from her daughter and grandchildren. Diane said she lived with Larry, her dog, and parrot, and that their relationship was supportive when she was sober, but that Larry became angry and verbally abusive when she drank.

3.14 In early May, Diane called 999 stating Larry had strangled her and was recorded as incoherent. Her daughter also contacted police, reporting Diane had made the same allegation to her. Officers attended and arrested Larry for assault and coercive control. Diane was placed in a hotel, with GDASS providing food and toiletries. Larry denied the

allegations, and due to insufficient evidence, no further action was taken. Diane was referred to MARAC, and following her temporary move to her daughter's, a MARAC-to-MARAC transfer was completed with a high-risk flag added to the new address.

3.15 In mid-May Larry contacted the housing office to say Diane had left and he wanted her name removed from the tenancy.

2022

3.16 Diane contacted her housing officer, visibly upset, stating she wished to end her tenancy and was staying with a friend in Devon. Her notes referenced MARAC and domestic abuse. Despite being advised of the consequences, Diane said she had no choice but to become homeless. An investigation was opened. Later that day, Larry called to report Diane had relinquished her tenancy, moved to Devon, and was an alcoholic. He was informed that an investigation was underway, and no immediate action would be taken.

3.17 In early April, Larry called police after receiving a message from Diane stating she intended to take her own life. He identified her as his ex-partner. When officers attended, Diane answered the door; the property smelled of urine and was generally unclean. Diane appeared unsteady and slurred her speech. A Vulnerability Identification Screening Tool (VIST) was completed, identifying her as medium risk due to her presentation and living conditions. Officers found unopened medication in Diane's name, which she said she couldn't swallow, and confirmed she had no intention of self-harm. Medication in Larry's name was removed as he no longer lived there.

3.18 In mid-April Diane reported Larry's new partner had sent her abusive messages. Larry's partner made a counter allegation which included threats to her daughter, no action was taken.

3.19 GHC records show that at the end of July, Larry was seen by Criminal Justice Liaison Service (CJLS) after he was arrested for assault by 'grabbing his partner by the throat' (There are no Police records for this incident, and it is unclear who the partner was or if it related to the incident in April).

3.20 In early December, Diane refused entry to the housing officer following neighbour complaints about her dog barking late at night, explaining it barked at passers-by. She said she was tidying the flat, felt very stressed after a recent seizure while shopping, and confirmed her Universal Credit was now set up. A follow-up visit was scheduled for one month later.

2023

3.21 In early January, Diane cancelled a visit with the housing officer due to feeling unwell, expressing anxiety about her dog and considering rehoming her. Two weeks later, a welfare visit was conducted following a lack of contact. Diane again denied access, stating she was unwell and distressed after giving money to a friend for food and prescriptions but receiving no response. She reported having no food or milk, feeling bullied by neighbours, and being too anxious to leave the flat or walk the dog. She also mentioned wanting to move due to struggling with the stairs after a fall. A meeting was arranged for the following week to support Personal Independence Payment (PIP) and Home Seeker applications; however, Diane was unable to attend and cancelled the appointment.

3.22 At the end of February, the housing officer saw Diane in her home; they recorded Diane was back with Larry, and he was cleaning the property. Neighbours were concerned that the arguments and fights may start again but there was a vast improvement with the animals.

3.23 Diane called her housing officer distressed in April stating Larry had taken her carpets, sofa and the money she had given to pay for the replacements. She was upset that she could not attend her job centre appointments to complete her PIP application. She was offered help with this and provided a food bank voucher.

3.24 At the end of May, Diane's neighbour complained to housing that Larry had confronted them. A welfare check was undertaken, Diane and Larry claimed the neighbour had been verbally and physically abusive to them, so they were trying to stay out of their way.

3.25 In June, Diane reported to police that Larry had entered her flat without permission using a key, despite the tenancy being in her name. Larry was overheard saying, "*Stop wasting their time I am getting my blood pressure medication*." No immediate attendance occurred as Larry left and no threats or violence were disclosed. The Triage Team later contacted Diane, who reported Larry had punched and damaged the door and refused to return the key. She declined to provide a statement. Larry was voluntarily interviewed in August, denied causing damage, claiming it was pre-existing. No further action was taken.

3.26 Gloucester County Council (GCC) helpdesk received a call from Larry on 16th August; he was concerned for Diane's self-neglect arising from her alcohol use. This was allocated to adult social care to proceed with a Section 42 enquiry (Care Act 2014[5]).

3.27 Two days later, Larry contacted First Point of Contact Centre (FPCC) reporting Diane was struggling mentally and physically, weighed under 7 stone, and was unable to weight bear, even to use the toilet. He said she had been on a five-day alcohol binge. He was advised her physical condition required investigation, and a GP assessment would be requested. That same day, the GP called Larry, who confirmed he had moved back in due to concerns about Diane's drinking.

3.28 Five days after the initial concern was raised with the GCC helpdesk, a social worker was instructed to liaise with the GP for an urgent visit to Diane. That same day, Diane's daughter contacted the helpdesk echoing Larry's concerns. The GP visited Diane later that day, noting she was unkempt but expressed a desire to improve. They assessed her as likely depressed and provided crisis support information.

3.29 On 22nd August, the GP informed the social worker of self-care concerns regarding Diane, though not deemed acute. A s42 enquiry was allocated for follow-up. The social worker spoke with Diane's daughter, who raised concerns about Diane being abusive toward Larry. Larry was also contacted and stated he believed Diane needed sectioning.

3.30 On 26th August, Larry called FPCC reporting Diane was bedridden in her own excrement, had not consumed alcohol for several days, but would drink anything available, often supplied by a neighbour. He said she hadn't left bed for 4–5 days, wasn't eating or drinking, and had lost weight. Although the GP had visited, no further support was offered.

[5] https://www.legislation.gov.uk/ukpga/2014/23/section/42

Larry believed Diane needed hospital treatment. He was advised to contact CGL for detox, but said Diane refused to engage and they had given up on her. He ended the call stating he would not return, and Diane would need to manage alone.

3.31 Three days later, the GP raised Diane's case at a safeguarding meeting and planned a social prescriber referral (offered via message days later). That same day, Larry called SWAST, who attended Diane's home. Diane reported being immobile, bedridden for five days, unable to walk, and without food or drink. The crew noted the bed lacked sheets, was soaked with urine, had faecal stains, and the kitchen was unkempt. Diane was taken to hospital, and an adult safeguarding referral was made. The hospital informed her social worker of the admission and the ongoing s42 enquiry regarding self-neglect, weight loss, domestic abuse history, and suicide risk was discussed.

3.32 Throughout September, there were multiple contacts with Diane, Larry, and agencies. Early in the month, Diane was admitted to hospital and expressed distress that Larry had told neighbours she was incontinent, which she found humiliating. She described Larry as controlling and agreed to a GDASS referral. Days later, she told the ward care navigator that Larry had visited, and they had agreed to remain friends. Diane declined home care and was discharged mid-September. Home visits were conducted by the social worker and care navigator. The NHS Referral Management Centre (RMC) attempted contact at the end of the month to offer social prescribing but was unsuccessful. Diane declined GDASS, however, accepted a mobile phone so she could receive and take calls.

3.33 At the beginning of November, the S42 was closed. Diane was seen by the Enablement Team where she and Larry stated they were coping well with daily living practicalities. Near the end of the month the GP raised concerns regards Diane worsening kidney functioning, follow up calls and messages were sent to Diane for support.

2024

3.34 Diane passed away in May.

4. Areas of focus[6]

<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="3">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></td><td>3. B)
Would the response be likely now?</td><td>4. B)
Do these contributory factors still hold?</td></tr>
</table>

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

4.1 The Trio of Vulnerability - Domestic Abuse, Mental Health and Substance use

4.1.1 Diane's situation was complex, marked by deteriorating physical and mental wellbeing, increased alcohol use, and alleged abuse from Larry. The trio of vulnerability refers to the overlapping issues of mental health, substance use and domestic abuse and when these factors are combined it can significantly increase the risk of harm. It is essential professionals have a thorough understanding of the trio of vulnerabilities and the link between each issue as this will help identify and offer effective support to everyone involved.

Domestic Abuse

4.1.2 Diane was subjected to persistent and escalating domestic abuse, much of which appeared to be characterised by coercive control. Her experiences included verbal degradation, surveillance, intrusion, and manipulation, behaviours that eroded her autonomy and contributed to her emotional and physical decline. Despite multiple disclosures to professionals and agencies, the abuse was often minimised, misinterpreted, or overshadowed by other presenting issues such as substance misuse and mental health.

4.1.3 When Diane's daughter alleged that her mother had been a victim of rape and coercive control, the response of Police was proactive and supportive. Diane denied all the allegations made; however, she did say there was some name calling. There are no records to indicate that a VIST was completed or what referrals were offered or made to specialist services. Since this time changes have since been made to ensure that f there are any allegations of rape or sexual assault then these cases will be automatically identified as high-risk and there must be consideration for MARAC (which did not happen in 2019).

4.1.4 These allegations of rape were not the only sexual abuse concerns raised. There were also concerns that Larry was coercing Diane to have sex with other men and that he was also using her alcoholism to coerce her into having sex with him. Although Diane denied this, it is unclear whether sexual coercion was ever explained to her. Additionally, it is unclear if she was ever offered specialist rape crisis support or sexual health services.

4.1.5 Sexual abuse, particularly within intimate relationships, is fundamentally about power and control rather than sexual gratification[7]. Coercion may be subtle, cumulative, and deeply embedded in the dynamics of dependency, addiction, and fear. Victims may not recognise their experiences as abuse, especially when coercion is normalised or masked by emotional manipulation. Shame, embarrassment, and fear of disbelief are powerful silencing forces. Research shows that survivors often struggle to name their experiences as abuse, using euphemisms or minimising language to cope with internalised stigma[8]. Shame can persist even after disclosure, manifesting in self-blame, secrecy, and identity confusion[9]. This is particularly true when the abuse is linked to substance use, which can further compound feelings of guilt and perceived complicity.

4.1.6 Diane's denial may therefore reflect not an absence of harm, but a lack of safe, trauma-responsive opportunities that explored and understood her experiences. Agencies have

[7] https://broxtowewomensproject.org.uk/sexual-abuse-in-intimate-relationships/
[8] https://www.psychologytoday.com/us/blog/experimentations/202301/relieving-the-shame-of-childhood-sexual-abuse
[9] https://journals.sagepub.com/doi/pdf/10.1177/1077559505276686

a duty to recognise that denial does not equate to consent or safety. The Crown Prosecution Service guidance on controlling or coercive behaviour emphasises the importance of identifying patterns of abuse, even when victims are unable or unwilling to articulate them[10]. Agencies should ensure that individuals like Diane are offered repeated, non-judgmental opportunities to access specialist support, including Independent Sexual Violence Advisors (ISVAs), rape crisis services, and counselling. They should also be proactive in explaining concepts such as sexual coercion and consent, particularly where substance misuse or mental health vulnerabilities are present.

4.1.7 Larry's behaviour towards Diane demonstrated multiple hallmarks of coercive control, including surveillance, intrusion, and verbal degradation. She did not have access to her own phone, he was known to monitor her phone calls and retained access to her property despite their reported separation, undermining her autonomy and ability to establish boundaries. Diane was subjected to repeated verbal abuse, including being called names such as "fat bitch" and telling neighbours she was incontinent; this not only humiliated her but also eroded her self-worth. Such behaviour is not incidental, it is a deliberate tactic used to destabilise victims, reinforce dependency, and diminish their sense of agency. Further evidence of controlling behaviour was seen when Larry packed Diane's hospital bag, including only a bikini and one shoe, an act that appeared intentionally demeaning and neglectful. It was raised at the learning event that where domestic abuse is known, if an alleged perpetrator packs a hospital bag, professionals should check its contents to ensure it meets basic needs and does not reflect further abuse or neglect.

4.1.8 Coercive control is often insidious and cumulative, operating through a pattern of behaviours that restrict freedom, isolate victims, and dismantle their identity. In Diane's case, the combination of verbal abuse, physical isolation, and emotional manipulation created a climate of fear and disempowerment. The impact of this form of abuse is profound: victims may internalise blame, experience chronic anxiety, and lose confidence in their ability to make decisions or seek help. Diane's deteriorating health and alcohol dependency further compounded her vulnerability, making it increasingly difficult to challenge or escape the controlling dynamics.

4.1.9 Professionals must recognise that coercive control does not always present as overt violence. It can manifest through subtle, persistent behaviours that strip away a victim's independence and distort their reality. Larry's behaviour, Diane's daughter's concerns and Diane's allegations should have been recognised as indicators of ongoing abuse. Agencies should be equipped to identify these patterns and respond with victim-centred approaches. An example of this includes ensuring that victims are not excluded from refuge or support services due to substance use, disability, or the presence of pets, factors which, in Diane's case, may have been decisive in her inability to leave.

4.1.10 In addition to these abusive behaviours, Diane and her daughter occasionally referenced financial abuse, although this was not formally recorded. Diane had told officers that she did not work, and Larry gave her money if she needed it. This dynamic indicates a power shift and no equality of funds. Additionally, it was not until 2022 that she confirmed her Universal Credit was set up and her PIP was never arranged. This meant she was financially dependent on Larry.

4.1.11 The couple may have experienced additional financial pressure if Larry had been furloughed due to his role during COVID-19, and additional financial pressures may have

[10] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

emerged within the relationship. While this does not minimise economic abuse, it may offer insight into the broader context of economic strain. According to Refuge, 1.6 million adults in the UK reported experiencing economic abuse that began during the pandemic[11]. The lockdown created conditions that allowed perpetrators to intensify control over finances, housing and access to resources, often continuing or escalating abuse post-separation.

4.1.12 Diane disclosed to the housing officer that she was not in receipt of PIP, and that Larry had taken her money to buy items. She also described how neighbours had taken her money, highlighting her vulnerability to exploitation beyond the intimate relationship. These disclosures suggest a pattern of economic disempowerment and social isolation, compounded by her physical health and substance use. The absence of formal recording of financial abuse may reflect a lack of professional awareness or confidence in identifying economic control, which is often minimised or misunderstood.

4.1.13 Economic abuse is now legally recognised under the Domestic Abuse Act 2021 as behaviour that substantially restricts a person's ability to acquire, use, or maintain money, property, or access to goods and services. It is rarely perpetrated in isolation: Refuge's research found that 85% of those experiencing economic abuse also faced other forms of domestic abuse. Diane's circumstances reflect this intersectionality, where financial exploitation coexisted with coercive control, verbal degradation, and sexual abuse.

4.1.14 These factors highlight the need for professional curiosity and contextual safeguarding when assessing risk during periods of national crisis. Practitioners must be equipped to recognise economic abuse not only as a standalone risk, but as part of a wider constellation of harm. This includes understanding how poverty, disability and social exclusion can increase vulnerability to exploitation, and how perpetrators may manipulate these conditions to entrench control. Multi-agency responses should ensure that victims are supported to access financial entitlements, protected from third-party exploitation, and offered advocacy that addresses the full spectrum of abuse.

4.1.15 Finally, we must explore the risk of physical abuse from Larry. Diane had been seen by police with visible injuries, including black eyes and a mark on her nose, which she attributed to tripping over her dog. Officers expressed concern that this explanation may not have been truthful. On another occasion, Diane disclosed that Larry had pushed her but insisted he had not been violent. These inconsistencies may reflect the psychological complexity of abuse disclosure, where fear, shame, and trauma can distort a victim's perception and reporting of harm. Victims may minimise or deny abuse to preserve a sense of control, avoid confrontation, or protect the perpetrator, particularly when trauma bonding or cognitive dissonance is present[12].

4.1.16 There were also two reports of strangulation, one in 2020 and another in 2021. Although the offence of non-fatal strangulation was not yet enshrined in law, Larry was arrested for coercive control and assault. It is unclear if Diane was advised to seek medical help and her medical notes do not indicate she sought help after these assaults. Strangulation is now recognised as one of the most lethal forms of abuse, often used to demonstrate dominance and instil fear. Research shows that even brief episodes of strangulation can cause traumatic brain injury, memory loss, and long-term neurological impairment, even

[11] https://refuge.org.uk/news/8-7million_economic_abuse_covid/
[12] https://neurolaunch.com/cognitive-dissonance-in-abusive-relationships/

in the absence of visible injuries[13]. Survivors may experience confusion, difficulty concentrating, and emotional dysregulation, which can further complicate their ability to articulate or even recognise the abuse they've endured.

4.1.17 The couple appeared to be caught in a recurring cycle of 'relative calm, managing the situation, an explosion, request for help, and then back to the beginning'. This pattern closely mirrors the cycle of abuse, which identifies four stages: tension-building, incident, reconciliation, and calm[14]. During the tension-building phase, stress accumulates, and communication breaks down, often leading to heightened anxiety and fear. The incident phase involves verbal, emotional, or physical abuse, followed by a reconciliation stage where the abuser may apologise or minimise the harm. The calm phase then offers a temporary reprieve, often giving victims a false sense of hope that things will improve.

4.1.18 This cyclical dynamic can lead to trauma bonding, a psychological response where victims form emotional attachments to their abuser as a survival mechanism. For Diane, this manifested in accepting help during crisis points but later withdrawing or feeling unable to continue engaging with support services. Such ambivalence is not uncommon; victims often experience confusion, shame, and fear of reprisal, which can inhibit help-seeking behaviours. The unpredictability of the cycle also creates challenges for professionals, as engagement may fluctuate depending on which phase the victim is in.

4.1.19 Understanding the cycle of abuse enables practitioners to offer trauma-informed support. It requires patience, consistency, and a non-judgmental approach that validates the victim's experience while gently reinforcing pathways to safety and autonomy. Diane's presentation, fluctuating between help-seeking and withdrawal should not be interpreted as resistance, but rather as a reflection of the psychological entrapment and emotional exhaustion inherent in abusive relationships.

4.1.20 Diane's presentation, marked by fluctuating disclosures, minimisation, and physical vulnerability, suggests that she may have experienced multi-layered abuse across physical, sexual, emotional, economic, and psychological domains. This underscores the importance of professionals adopting a holistic lens when assessing risk and safeguarding needs. Fragmented disclosures should not be dismissed as unreliable but rather understood as indicators of complex trauma and coercive control. Agencies must be equipped to identify and respond to the full spectrum of abuse, including its invisible and cumulative impacts.

Alcohol

4.1.21 Diane disclosed to the mental health liaison team in April 2021 that her drinking had increased to 1.5 bottles of wine a day over 2 years. Drinking 1.5 bottles of wine daily, is the equivalent to roughly 12–15 units of alcohol and can have profound effects on both physical and mental health, as well as a person's ability to function day to day. Mentally, chronic alcohol use can worsen depression and anxiety, impair cognitive function, and lead to alcohol-related brain damage, including memory loss and reduced decision-making capacity[15].

[13] https://www.domesticshelters.org/articles/health/how-strangulation-affects-the-brain
[14] https://www.verywellhealth.com/cycle-of-abuse-5210940
[15] https://www.rcpsych.ac.uk/mental-health/mental-illnesses-and-mental-health-problems/alcohol-mental-health-and-the-brain

4.1.22 It is unclear how long Diane had been using alcohol or when it developed into dependency, but between 2019 and her death, her use significantly increased, impacting both her mental wellbeing and physical health[16]. Diane disclosed a history of childhood sexual trauma, and although she had received counselling, the long-term psychological impact of such trauma cannot be underestimated. Research shows that survivors of childhood abuse are significantly more likely to develop substance use disorders, with alcohol often used as a coping mechanism to numb emotional pain, suppress traumatic memories, or manage anxiety and insomnia[17]. However, while alcohol may offer temporary relief[18], it can exacerbate trauma symptoms, impair emotional regulation, and contribute to a cycle of dependence and deteriorating mental health[19].

4.1.23 Diane's alcohol use was not an isolated issue; it was deeply entangled with her experiences of coercive control and exploitation. In October 2019, her daughter reported that Larry controlled Diane's finances and used her alcoholism to coerce her into sex. This pattern of abuse was echoed in Diane's own disclosures, including a call to Police in July 2020 where she reported verbal abuse and the removal of alcohol by Larry. The manipulation of her dependency became a tool of control, reinforcing her isolation and undermining her autonomy.

4.1.24 Alcohol also intersected with Diane's suicidal ideation. In February 2019, she took an overdose and told paramedics she did not want to wake up. In April 2022, Larry contacted police after receiving a message from Diane stating she intended to take her own life. These incidents reflect the profound psychological distress Diane was experiencing, compounded by the disinhibiting and depressant effects of alcohol[20]. Studies show that alcohol misuse is associated with a 94% increase in suicide risk, particularly among women with prolonged heavy drinking[21].

4.1.25 By August 2023, Diane's physical health had deteriorated significantly. She was bedbound, weighed less than seven stone, and was unable to weight bear even to use the toilet. Alcohol misuse is known to contribute to malnutrition, muscle wasting, and immune suppression, all of which may have accelerated her decline. Despite these indicators, there is limited evidence of coordinated intervention to address her alcohol dependency in the context of trauma and abuse.

4.1.26 Diane's case illustrates the need for a response to alcohol dependency that recognises its role as both a symptom and a consequence of abuse. Her experiences highlight the importance of:

- Integrated support: Alcohol misuse should be addressed alongside mental health, trauma, and domestic abuse, not in isolation.
- Professional curiosity: Practitioners must look beyond surface-level disclosures and consider the wider context of control, coercion, and trauma.
- Non-exclusionary services: Diane's inability to access refuge due to substance use and pets underscores the need for inclusive, flexible support models.
- Routine screening and referral: Agencies should routinely assess for alcohol-related harm and suicidal ideation, particularly in cases involving coercive control.

[16] https://www.ias.org.uk/report/the-physical-and-mental-health-effects-of-alcohol/
[17] https://www.goodtherapy.org/blog/alcohol-trauma-drinking-as-way-to-cope-with-past-0602174
[18] https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/alcohol-and-mental-health
[19] https://www.joinreframeapp.com/blog-post/examining-the-relationship-between-alcohol-use-and-coping-with-trauma
[20] https://www.psychologytoday.com/us/blog/psymon-says/202310/the-link-between-alcohol-and-suicide
[21] https://www.drinkaware.co.uk/facts/health-effects-of-alcohol/mental-health/alcohol-and-suicidal-thoughts

4.1.27 Diane's alcohol use was not simply a coping mechanism, it was a red flag, a symptom of deeper harm, and a vulnerability that was exploited. Her story demands a systemic response that sees the whole person, not just the presenting issue.

Mental Health

4.1.28 The interwoven complexities of domestic abuse, mental health, and substance use created barriers to consistent engagement, as each domain required individualised responses while also influencing the others. While mental health assessments were routinely conducted and documented in detail, they often lacked depth in exploring the lived experience of domestic abuse. The absence of curiosity around the 'why': why she was struggling, why she was drinking, why she was disengaging, meant that the abuse remained unspoken and unaddressed. Without explicitly naming domestic abuse or asking about it in a way that felt safe and relational, professionals risked reinforcing silence rather than disrupting it. This highlights the need for routine enquiry to be more than a tick-box exercise: it must be relational, culturally responsive, and attuned to the interplay between trauma, coping, and risk.

4.1.29 When Diane declined care after her overdose attempt, it is unclear if her capacity was assessed. If she had lacked the capacity to decline care, then agencies had a duty to act in her best interests, considering her wishes, feelings, values, and the least restrictive option. Under the Mental Capacity Act 2005, a determination of capacity must precede any best interest decision. Capacity is decision-specific and time-specific, and professionals must establish whether the individual can understand, retain, weigh, and communicate decisions about care and support. However, in the absence of a formal capacity assessment (potentially hindered by remote working and reduced face-to-face contact) it remains unclear whether she was able to make informed decisions about her care or whether her refusal was rooted in impaired cognition.

4.1.30 Frameworks such as the Care Act 2014, Mental Capacity Act 2005, and Making Safeguarding Personal should have guided agency responses. When assessing an individual's capacity, consideration of the impact of coercive and controlling behaviour should be included. Coercive control can significantly impair autonomy, distort perception of risk, and undermine confidence in decision-making. Victims may appear to have capacity on the surface, yet their choices may be shaped by fear, manipulation, or conditioned compliance. The Mental Capacity Act requires professionals to assess whether a person can weigh information relevant to a decision, but in cases of coercive control, the ability to weigh risks may be compromised by psychological entrapment or trauma responses. Therefore, capacity assessments must be trauma-aware and contextualised within the dynamics of abuse. Recognising coercive control as a potential barrier to free and informed decision-making is critical to safeguarding practice and should inform both the assessment process and any subsequent best interest decisions.

4.1.31 This case highlights the critical need for professionals to develop a deeper understanding of the interrelationship between domestic abuse, mental health, and substance use. Each of these areas can independently present significant risk, but when they co-exist, they often compound one another, creating complex barriers to engagement, disclosure, and recovery. For Diane, alcohol use may have been both a symptom and a coping strategy for trauma and abuse, while deteriorating mental health likely reduced her capacity to seek or sustain support.

4.1.32 Professionals must be equipped to recognise how these vulnerabilities interact, for example, how substance use may mask or exacerbate mental health symptoms, or how domestic abuse may undermine a victim's ability to engage with services. A siloed approach risks missing the full picture. Instead, a trauma-informed, multi-agency response that routinely explores the dynamics of abuse, mental health, and substance use together is essential. This includes consistent routine enquiry, curiosity about the lived experience of the individual, and coordinated care planning that reflects the complexity of their needs.

4.1.33 Since this time GHC have introduced a dual diagnosis specialist who supports practitioners with patients who have mental ill health and alcohol or drug addiction. Additionally, GDASS now have a specialist IDVA in alcohol/drugs and mental health to provide a more holistic response to high-risk victims. With these specialist roles, the care package and assessment should enhance the support available to those with these intersecting complexities.

4.2 Self-neglect and Carer responsibility

4.2.1 Diane's presentation of self-neglect must be understood within the context of the trio of vulnerability. These three factors are frequently interlinked and mutually reinforcing, creating a complex web of risk that can severely impair an individual's ability to care for themselves. Research by Braye, Orr, and Preston-Shoot (2014) highlights that self-neglect often emerges from such intersecting adversities, and that effective intervention requires practitioners to recognise the underlying trauma and relational context driving the behaviour.

4.2.2 Despite multiple agency contacts, Diane's self-neglect was not consistently identified or addressed as a safeguarding concern. This reflects a broader systemic challenge: self-neglect is frequently misunderstood or minimised, especially when the individual retains mental capacity or declines support. Yet the Care Act 2014 includes self-neglect within its statutory definition of abuse and neglect, obligating agencies to act when care and support needs impair a person's ability to protect themselves. The lasting impact of unaddressed self-neglect can be profound, ranging from preventable health deterioration and increased hospital admissions to premature death. It also exacerbates social isolation and entrenches dependency on potentially harmful relationships, as seen in Diane's reliance on Larry for basic care.

4.2.3 Agencies must be equipped to recognise self-neglect not just as a behavioural issue, but as a symptom of deeper systemic vulnerability. This requires coordinated responses that prioritise relationship-building, persistence and holistic assessments. Without this, individuals like Diane remain invisible within the system, caught in cycles of harm that are both preventable and predictable.

4.2.4 Diane's case highlights a critical learning point across health, social care, and safeguarding: self-neglect must be understood as a manifestation of complex vulnerability, not simply as a lifestyle choice or refusal of care. In Diane's case, her reliance on an alleged perpetrator for care, her isolation, deteriorating physical and mental health, alcohol dependency, and domestic abuse created a layered and compounding risk profile that impaired her ability to meet her own basic needs. Despite repeated contact with services, these different presenting concerns should have

triggered professional curiosity and a coordinated safeguarding response so that her self-neglect could be appropriately responded to.

4.2.5 The lasting impact of unaddressed self-neglect is profound: it increases the risk of serious harm, hospitalisation, and premature death, while entrenching dependency on unsafe relationships. Diane's case illustrates how when self-neglect is not acted upon, it can perpetuate cycles of harm, particularly when the individual is experiencing coercive control or substance misuse.

4.2.6 To assist practitioners, agencies must develop a shared understanding of self-neglect as a safeguarding issue, especially when it coexists with the trio of vulnerability. This requires:

- Trauma-aware practice that prioritises trust, persistence, and relational engagement.
- Holistic assessments that explore the interplay between mental health, substance use, and domestic abuse.
- Multi-agency coordination to ensure that no single service bears the burden of response alone.

4.2.7 By embedding these principles into everyday practice, professionals can better identify and support individuals like Diane, whose needs may be hidden beneath layers of complexity, but whose risks are both real and preventable.

4.2.8 It was a significant oversight that Larry was never recorded as Diane's carer or offered a carer's assessment by any agency, despite his repeated expressions of emotional strain and practical difficulty in supporting Diane. Under the Care Act 2014, carers have a legal right to an assessment when it appears they may need support, regardless of whether they formally request one. Larry had clearly articulated that he was struggling, he had moved back in due to concern for Diane's wellbeing but later disclosed that he felt overwhelmed and unable to cope. These are textbook indicators of carer stress and potential burnout, which should have prompted a proactive response.

4.2.9 Offering Larry a carer's assessment would have served several vital functions:

- Identifying his support needs, including emotional, financial, and practical pressures and validating his experience as a carer.
- Exploring respite options, emotional support, or community resources that could have helped him sustain his role without compromising his own wellbeing.
- Creating space for honest dialogue about the dynamics in the home, including any safeguarding concerns or risks to Diane.
- Facilitating a more accurate picture of Diane's lived experience, especially if Larry was her primary or only source of care.

4.2.10 This omission not only denied Larry access to support in his own right but also limited professionals' ability to understand the relational dynamics and potential safeguarding concerns within the caring arrangement. Crucially, systems must be equipped to recognise and respond to the power imbalances and risks of domestic abuse that can exist within carer relationships, particularly where the caring role masks coercive control or where the carer themselves may be vulnerable.

4.2.11 Domestic abuse should be a core consideration within care needs assessments, not only to ensure appropriate support and protection for both parties, but also to avoid inadvertently reinforcing unsafe dynamics. In cases like Diane's, where vulnerabilities are compounded by alcohol, isolation and limited agency engagement, the absence of such

scrutiny can result in missed opportunities to intervene, protect, and uphold the rights of those most at risk.

4.2.12 As a result, the absence of a carer's assessment meant missed opportunities to strengthen the safeguarding response for Diane. Supporting Larry could have indirectly improved Diane's safety and stability, whether through better care provision, clearer boundaries, or enabling Larry to disengage safely if the situation became untenable. It also reflects a broader systemic issue: the tendency to overlook carers in safeguarding contexts, particularly when domestic abuse, substance use, or complex health needs are involved.

4.2.13 In short, failing to offer Larry a carer's assessment not only neglected his rights and wellbeing, but also undermined the potential for a more holistic, person-centred safeguarding approach for Diane. It also meant missed opportunities to intervene meaningfully, challenge coercive dynamics, and potentially prevent further harm. It also reflects a gap in professional curiosity and safeguarding culture, particularly when domestic abuse intersects with substance use and mental health.

4.2.14 All agencies involved in adult safeguarding should ensure that domestic abuse is explicitly considered within carer's assessments and care needs evaluations. Practitioners must be supported through training and supervision to identify power imbalances, coercive control, and other forms of abuse that may be present within caring relationships. This includes recognising when the caring role itself may be used to exert control or limit access to support.

4.2.15 Embedding domestic abuse awareness into assessment frameworks is essential to safeguarding those most at risk, ensuring that care plans do not inadvertently reinforce unsafe dynamics, and that both carers and those they support are offered appropriate, trauma-focused interventions. Multi-agency safeguarding partnerships should review current practice and guidance to strengthen this lens across adult social care, health, and housing pathways.

4.3 Multi-Agency safeguarding and Decision Making

4.3.1 The abuse Diane experienced appears to have escalated over the final five years of her life, with allegations of strangulation, financial control, and emotional harm. As already highlighted in s4.2, despite clear safeguarding concerns, no formal multi-agency meeting was convened and sharing information was limited.

4.3.2 Although some professionals were proactive in identifying high-risk factors and referring Diane to MARAC on four occasions, the multi-agency response was fragmented, despite multiple agencies interacting with Diane. Of the four MARAC referrals, two were MARAC-to-MARAC transfers, while the other two were not heard as they did not meet the threshold. At the time, MARAC capacity was impacted by COVID-19 related pressures and staffing shortages. Nevertheless, agency engagement could have been stronger, particularly given that Adult Social Care were unaware of the concerns. The lack of information sharing meant no earlier intervention was possible, despite clear safeguarding risks.

4.3.3 Although MARAC-to-MARAC transfers were initiated, the process was reciprocated when Diane returned to Gloucestershire. Crucially, action plans from the originating MARAC were not shared with local agencies. This represents a significant missed opportunity to

ensure continuity of safeguarding measures and risk management. According to SafeLives guidance, MARAC-to-MARAC transfers are intended to facilitate seamless information sharing and coordinated support when a victim relocates across local authority boundaries. Failure to complete the transfer and disseminate the action plan undermines the purpose of MARAC as a multi-agency forum for safeguarding high-risk victims. In Diane's case, this gap contributed to the fragmented responses and delayed intervention, particularly as Adult Social Care remained unaware of the escalating concerns.

4.3.4 Even though the MARACs were not heard, health and housing records referenced two referrals and were therefore aware of the domestic abuse present in Diane's life. However, there is no indication that the GHC practitioners or housing officers raised concerns or asked questions with Diane regarding domestic abuse. This again meant missed opportunities to have created an environment for her to share any concerns and enhanced their ability to risk assess her situation.

4.3.5 GHC practitioners should have ensured domestic abuse questions were asked as it is part of the Routine Enquiry Trust Policy. In 2021, after Diane's intentional overdose, she disclosed abuse from Larry, was blaming herself and her alcohol use and that she was struggling. Two MARAC referrals were held on her GHC records; however, they did not complete a DASH. Although initial concerns were responded to, there was little exploratory investigation to either gather information from other agencies, her daughter or from Diane when she was sober. Additionally, no information was shared with MARAC or partner agencies and although she was provided GDASS and CGL information, sharing information with wider partners would have been able to support future decision making. Since Diane's death, changes to the MARAC process and capacity have improved, allowing more timely and thorough case discussions and decision making.

4.3.6 An additional concern and high-risk factor which should have raised concerns and influenced agencies decisions was Diane's intentional overdoses. The VKPP[22] report now shows 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 Diane, whose sense of entrapment, hopelessness, and fear became overwhelming. Suicidal ideation 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. Systems 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.

4.3.7 A further opportunity to have completed the DASH or explored domestic abuse in further detail was by Diane's housing officers. Even though the service was aware of the MARAC referrals and Diane had made disclosures that Larry had returned to the flat and had then taken her money and furniture, domestic abuse was never explored or assessed. They were in a unique position to influence the decisions being made and could even have been the lead for any action plans. That said, even though the service was aware of the MARAC, there was very little interaction with other services and therefore they were

[22] https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/

unaware of the attempts to see or speak to Diane. Again, this service was in a position to have carried out joint appointments with other agencies, however, they were never included in any discussions or plans.

4.3.8 Stroud District Council's Housing Team received multiple complaints from neighbours regarding anti-social behaviour associated with Diane's property. Consequently, most interactions with Diane were framed through a tenancy management lens, focusing on behavioural enforcement rather than safeguarding. This reflects a broader pattern seen nationally, where housing providers respond to noise complaints, often involving shouting, banging, or disturbances as anti-social behaviour, without considering the possibility of domestic abuse.

4.3.9 In Diane's case, this approach contributed to a narrow understanding of her circumstances and missed opportunities to identify her as a victim. Domestic abuse was rarely considered as a potential underlying factor, despite the presence of multiple vulnerabilities and known risk indicators. This misclassification can result in victims being penalised or evicted, rather than supported.

4.3.10 Housing officers and call handlers need to be equipped with the skills and confidence to apply professional curiosity, review historical patterns, and explore the context behind reported behaviours. This includes recognising the signs of coercive control, trauma responses, and disguised compliance. A more holistic approach would enable housing teams to respond appropriately, offering support and protection rather than enforcement and contribute meaningfully to multi-agency safeguarding efforts.

4.3.11 Since this time, Stroud District Council has had a strategic change in their housing team, and in terms of how the council views safeguarding. There has been and continues to be work regarding safeguarding and domestic abuse specifically, embedding change. Housing has and continues to have a unique opportunity as they can access people's homes, therefore, they can see individuals face-to-face. Up until Diane's death, Stroud did not have a domestic abuse policy, however this has changed. Not only is there one in place, but the council are also exploring DAHA accreditation which will enable to them to have a framework to work with, improving responses to victims.

4.3.12 Gloucestershire Constabulary were continually proactive in completing the DASH and VIST. In April 2022, a VIST was completed after officers were concerned for the condition of the home and that she had stated she was going to take her life. However, the 'Consent to Share" box was ticked as 'No' and it is believed it was not completed in her presence. Even though it was submitted to Adult Social Care, several issues arose from this; firstly, Diane's name was incorrectly spelt and therefore never linked to Diane or action taken. This incident was only found by the Police representative for the review based on Diane's address and date of birth. This type of error could cause severe consequences and highlights the importance of officers spelling names correctly and, if noticing errors, knowing how to correct them and who to inform. Secondly, when "No" is ticked, then Adult Social Care will not take action. This highlights the importance that response officers know this so they can obtain consent to share when in the person's presence.

4.3.13 A further opportunity where risk and information could have been shared was in mid-April 2022 when Diane reported Larry's partner was sending abusive messages and was attending Diane's address as Larry was still living there. Larry's partner then made counter allegations of abuse from Diane. Although the sergeant closed the crimes, no VIST was

completed. Although the named parties were not in a domestic relationship, they were personally connected, and it could be argued that Larry was taking advantage of Diane's vulnerabilities by remaining at her address and beginning a new relationship whom he was inviting around to the address. Therefore, Diane could have been assessed as an Adult at Risk. If officers had been aware of the previous history (i.e. her alcohol dependency, mental ill health and domestic abuse) then it may have been more likely a VIST would have been completed but it would not be standard in these circumstances. Since this time, Gloucestershire Constabulary's completion of VISTs is more consistent, improving frontline identification and referral as there is now a Police Adult at Risk decision maker in the MASH who reviews all VISTs and ensures information is shared.

4.3.14 What has been evident within this review is the lack of referrals to Adult Social Care and earlier intervention for Diane and Larry. Even though interaction by agencies with the couple is recorded from 2017, adult social care only became aware in August 2023. Prior to this there had been four MARAC referrals, repeated hospital admissions, liaison with the GP, Police attendance, referrals to GDASS and GHC. However, there are no records to indicate a referral to adult social care was ever discussed with her and no agency referred to adult social care other than SWAST in 2023. These were significant missed opportunities as the constellation of risk indicators surrounding Diane (spanning 6 years) was not recognised and therefore earlier safeguarding action and multi-agency discussions were not made.

4.3.15 The lack of leadership and coordination meant that no single agency took ownership of risk escalation or coordinating a safeguarding response resulting in no other multi-agency meetings even though opportunities were present due to the complexity of the case. This absence of sharing of information created a challenge when trying to establish which agency was actively involved, who had the opportunities to engage with Diane and who would be best placed to offer support. Examples of this was the fragmented contact between the social worker, housing, mental health services, Police and GDASS. The disjointed information sharing and joint decision making meant missed opportunities for collaborative planning and risk mitigation. This highlights the need for clearer thresholds, escalation routes, and designated leadership roles within multi-agency partnerships.

4.3.16 The absence of a clear decision-making framework contributed to siloed responses. A well-structured Multi-Agency Risk Management (MARM) process (now being introduced in Gloucestershire) would have provided a consistent mechanism for managing complex risk, ensuring shared accountability and timely escalation.

4.3.17 Had Adult Social Care been involved earlier, a strategy, s42 enquiry or MARM could have been initiated to assess Diane's needs and risks years before it was at such a critical stage. A multi-agency safeguarding plan could have been developed and Diane may have received advocacy, housing support, or protection measures that reduced her exposure to harm. Since Diane's death there is improved shared responsibility between agencies responding to adults at risk experiencing domestic abuse which is explored in detail within the MASH.

4.3.18 A s42 enquiry would have been particularly important during earlier interactions with Diane, when multi-agency working was limited and protective measures were sparse. A timely s42 enquiry could have facilitated a more robust exploration of domestic abuse within the relationship, including identifying key pressure points and patterns of harm. It may also have prompted agencies that were struggling to engage with Diane to consider

more creative approaches, such as leveraging housing services as a safe and non-stigmatising route to contact and support her.

4.3.19 The absence of referrals to adult social care from partner agencies meant that the s42 enquiry was not initiated until only months before Diane's death. This delay represents a significant missed opportunity to coordinate safeguarding responses, build trust, and intervene meaningfully in Diane's life at a time when she may have been most at risk.

4.3.20 Diane's hospital admission in August 2023 marked a turning point in how services collaborated in her support. The social worker worked closely with the hospital, GCC care navigator, GP, and Enablement team, demonstrating the value of integrated care when agencies are aligned around a shared goal. This coordinated approach enabled professionals to visit Diane at home, offer support from CGL and GDASS, assist her in applying for PIP, and help manage her Universal Credit journal and household bills. It would have been beneficial for the housing officer to have been included within this plan as they were unaware of the support in place. This would have ensured they could carry out regular visits, monitor Diane's condition, the condition of the house and assess the risks to her from Larry. That said, the level of wraparound support demonstrated by agencies during this period reflects the principles of community-based multidisciplinary teams (MDTs), which research suggests can improve perceived quality of care and access, particularly for those with complex needs (Health Foundation, 2023).

4.3.21 The improved engagement in 2023 post-admission suggests that crisis points can act as gateways to more meaningful intervention but also raises questions about why such collaboration wasn't initiated earlier. Had this level of coordination been in place sooner, Diane may have received more consistent support, reducing her reliance on unsafe relationships and potentially mitigating the escalation of harm. This again reinforces the need for early, integrated responses that centre on the individual's lived experience and ensure that safeguarding is not reactive, but anticipatory and sustained.

4.3.22 A recurring theme and point of discussion within the learning event was Diane's disengagement and the myth of choice, which often resulted in cases being 'open or closed'. Although services made repeated attempts to follow up, they were quick to close the case when Diane did not respond. She was frequently unreachable by phone, yet there appeared to be limited reflection on whether she was able to access or use the phone, or whether the timing of calls were appropriate, for example, had Diane been drinking, and when might have been the best time to call to encourage engagement? The assumption that Diane had her own phone or could answer the phone overlooked potential barriers, and with greater professional curiosity and a willingness to challenge assumptions, alternative methods of engagement may have been identified. Furthermore, Diane could not drive, raising questions about how she was expected to attend appointments without practical support from Larry.

4.3.23 The assumption that non-response equals non-interest fails to account for the reality of chaotic, trauma-impacted lives. Disengagement should not be seen as a choice, but as a symptom of unmet need. Systems must be more flexible in their language and approach, recognising that people with multiple disadvantage often require persistence, creativity, and relational continuity and not rigid thresholds and time-limited offers.

4.3.24 When a decision is made to 'close' a case, current structures often require individuals to start from the beginning each time they seek help, retelling their story and re-navigating

eligibility criteria. This is not only inefficient but re-traumatising. There must be easier routes back into support, especially for those whose lives do not fit neatly into service pathways.

4.3.25 This underscores the statutory responsibilities enshrined in the Care Act 2014, which mandates that local authorities promote wellbeing, prevent escalation of need, and safeguard adults at risk of abuse or neglect. The Domestic Abuse Act 2021 further reinforces the duty to recognise domestic abuse in all its forms, including coercive control, economic abuse, and psychological harm, and to respond with sensitivity and accountability. When systems close cases due to non-engagement or fail to explore the underlying causes of distress, they risk breaching these duties and perpetuating harm.

4.3.26 A trauma-sensitive, flexible approach is not just best practice, it is a legal and moral obligation. Systems should offer warm re-entry points, relational handovers, and continuity of care that honours the complexity of someone's journey. Flexibility, not rigidity, is the foundation of ethical safeguarding. Services must be designed to accommodate complexity, honour lived experience, and offer pathways that are accessible, persistent, and rooted in relational trust.

4.4 Impact of COVID-19

4.4.1 Agencies were operating under immense strain during the pandemic, with staff redeployment, illness, and rapid policy shifts. This context may have affected the depth and consistency of safeguarding responses, particularly for cases that didn't present as immediately high-risk. This review offers an opportunity to reflect on how systemic pressures shape professional judgement and prioritisation.

4.4.2 Although contact with services increased from 2021, there were no recorded interactions with Diane until the summer of 2020, which may correlate with the national COVID-19 lockdown[23]. During this period, individuals were required to stay at home, and services had to rapidly adapt how they engaged with clients. This may reflect a broader phenomenon of temporal blind spots - periods during lockdown where risk escalated but visibility diminished. This raises questions about how safeguarding systems account for "silent" harm during national emergencies, and whether retrospective analysis can better capture missed opportunities for intervention.

4.4.3 COVID-19 didn't create new vulnerabilities; it amplified existing ones. Diane's experiences of isolation, emotional strain, and alcohol dependency were likely intensified by the pandemic. It functioned as a risk multiplier, compounding trauma, reducing protective factors, and heightening the lethality of abuse. This underscores the need for safeguarding frameworks that are responsive to environmental stressors and not solely individual behaviours.

4.4.4 The initial lockdown had a profound impact across the UK, with research showing a deterioration in mental health, increased alcohol consumption, and a rise in hidden domestic abuse. A cross-sectional study found that 17% of UK adults increased their alcohol use during lockdown, and those individuals were significantly more likely to experience poor mental health and depressive symptoms[24]. Diane and Larry both voiced how the restrictions affected their mental wellbeing, describing feelings of isolation and

[23] 23/03/2020 – 16/06/2020 (there were two subsequent ones: two weeks in November 2020 and January 2021)
[24] https://pure.ulster.ac.uk/ws/portalfiles/portal/88936188/Alcohol_use_and_mental_health_during_COVID_19_lockdown.pdf

emotional strain. This therefore may have shaped their interactions with services, each other, and their own coping strategies. Understanding these emotional landscapes is crucial for interpreting behaviour, assessing risk, and designing interventions that honour lived experience.

4.4.5 COVID-19 significantly impacted how all agencies interacted with individuals, particularly those at risk of harm. Face-to-face contact was drastically reduced, with many safeguarding enquiries and assessments conducted via telephone or video call. The shift to remote contact disrupted relational practice, which is foundational to trauma-informed engagement. For individuals like Diane, who may already struggle with trust, shame, or fear of judgement, the absence of in-person interaction could have hindered disclosure and help-seeking. This highlights the relational cost of digital safeguarding and the importance of rebuilding trust post-pandemic.

4.4.6 While this shift created barriers to building trust and fully understanding lived experiences, especially for those with complex needs, it also accelerated the adoption of digital tools that have strengthened multi-agency collaboration. Online meetings have made it easier to convene professionals across services, improving information sharing and enabling more timely decision-making. However, the client-facing aspect of safeguarding has, in some cases, been diminished. The challenge moving forward is to retain the efficiencies and connectivity of digital working while re-establishing relational, in-person engagement that offers meaningful intervention.

4.4.7 Even though digital tools improved multi-agency coordination, they also exposed inequities in access and engagement. Victims without safe devices, private spaces, or digital literacy may have been excluded from support. Diane's experience (she had no access to a phone during this time) invites reflection on how digital safeguarding can be both enabling and excluding and how future service models must balance efficiency with equity.

5. Recommendations

5.1 **Recommendation 1**

To ensure effective multi-agency support for individuals with overlapping vulnerabilities (such as substance dependency, mental health challenges, domestic abuse, and self-neglect), existing processes such as MARAC must ensure actions plans fully address and consider the risks identified and that multi-agency partners are active participants in the collective safeguarding for victims.

5.2 **Recommendation 2**

Stroud District Council's Housing Team are to consistently attend and provide meaningful contribution to both the MARAC and MASH processes.

5.3 **Recommendation 3**

Gloucestershire Strategic Housing Partnership are to prioritise achieving Domestic Abuse Housing Alliance (DAHA) Accreditation to embed best practice in responding to domestic abuse across housing services.

5.4 **Recommendation 4**

The Domestic abuse training pathway commissioned as part of the GDASS should ensure the findings from tis review are embedded, explicitly including the Trio of Vulnerability and equip practitioners with the skills to apply professional curiosity when navigating complex, intersecting risks.

6. Conclusion

6.1 Diane's life was marked by profound complexity, intersecting experiences of trauma, substance dependency, mental ill-health, domestic abuse, and self-neglect. Her story reveals the cumulative impact of systemic fragmentation, missed opportunities for coordinated care, and the consequences of failing to see the whole person behind presenting behaviours.

6.2 Diane was not invisible; she was known to many services. But the absence of a unified, compassionate response meant her voice was often lost in procedural noise. Her death must not be viewed as inevitable, but as a call to action: to build systems that are not only reactive but relational, not only risk-focused but rights-based.

6.3 The recommendations in this review are designed to drive meaningful change. They aim to strengthen safeguarding, improve professional confidence, and ensure that individuals like Diane are met with dignity, consistency, and care.

6.4 Diane mattered. Her life, and her death, must shape how we listen, how we lead, and how we learn.

Appendix 1 – Glossary

Acronym	Description
COVID-19	A contagious disease caused by the coronavirus.
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.
GCC	Gloucestershire County Council
GP	General Practitioner – Provide community medical care
IDVA	Independent Domestic Violence Advocate
MARAC	Multi-Agency Risk Assessment Conference discusses high-risk cases of domestic abuse.
MASH	Multi-Agency Safeguarding Hub
OPCC	Office of the Police Crime Commissioner
VAWG	Violence Against Women and Girls
VIST	Vulnerability Identification Screening Tool is submitted whenever a police officer identifies a person (adult or child) with care or support needs and / or is at risk of abuse or exploitation.

Appendix 2 – Agencies involved (Hannah can you add anyone who was on the panel but did not provide an IMR)

Agency	Role and department	Report provided	Panel member
Bielec Consultancy Ltd	Chair and Author	N	Y
Gloucestershire Council	Adult Social Care	Y	Y
Gloucestershire Constabulary	MARAC Coordinator	Y	Y
Gloucestershire OPCC	VAWG Policy and Strategy Lead VAWG Research Officer	N/A N/A	Y Y
Stroud Council	Senior Housing Officer	Y	Y
GDASS	Service Manager	Y	Y
VIA (Drug and Alcohol Service)	Service Manager	N	Y
NHS Gloucestershire ICB	Designated Nurse for Safeguarding Adults	Y	Y