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Gloucestershire Domestic Abuse Related Death Review Learning Event



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Office of the Police &
Crime Commissioner
for Gloucestershire

Key Themes from Domestic Abuse Related Death Reviews in Gloucestershire

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Introduction

Domestic Abuse Related Death Reviews (DARDR)

- Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence Crime and Victims Act 2004, with the provision coming into force in April 2011.
- Domestic Homicide Review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
 - a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
 - a member of the same household as himself.held with a view to identifying the lessons to be learnt from the death.
- The statutory DHR guidance also outlines that where a victim takes their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship; a DHR should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.
- The Victim and Prisoner Act 2024 made the change to reviews being called Domestic Abuse Related Death Reviews (DARDRs).



Introduction

Purpose of a DARDR

- a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- e) contribute to a better understanding of the nature of domestic violence and abuse; and
- f) highlight good practice.



Introduction

DARDR Identification Mechanism (in cases of death by suicide)

- Cases are highlighted now through monthly reports from Gloucestershire Constabulary Intelligence. In addition, any other agency and/or suicide prevention partnership can bring cases forward for consideration
- Expert panel has been convened and meets monthly to support CSP decision making

Local criteria developed to aid decision making:

- A domestic Abuse incident occurred close to the death (within a week)
- The victim was known to be a high-risk victim of DA within the last year
- The victim was known to specialist domestic abuse services within the last year
- The victim had been a long-standing victim of domestic abuse over a number of years; considering multiple perpetrators over this time period.
- Domestic Abuse concerns have been identified and communicated by family/friends of the victim.
- Domestic abuse was identified by the victim prior to their death as a causal factor in their decision making.



Introduction

DARDRs in Gloucestershire over time

- There have been 32 reviews commissioned in Gloucestershire since DARDRs came into statute (as of 8th June 2026)
- 19 of these have been for cases of suspected suicide / unexplained / drugs related
- 18 reviews have been published
- There have also been three rapid review cases held which are not counted in the 32
- There are currently four reviews and three rapid reviews awaiting Home Office Approval / Publication



Research

Domestic Abuse Related Death Reviews (DARDR) at the time of writing the report

- On 1st July 2025 there were 13 active DARDRs being undertaken in Gloucestershire and 3 Rapid Reviews
- Between 2016 and 1st July 2025 there had been 16 DARDRs related to death by suspected suicide in Gloucestershire, making up 67% of all DARDRs commissioned since that date.

Suspected Perpetrators of DA

- Suspected perpetrators who died by suspected suicide do not meet the criteria for a review, but are discussed in the Expert Panel to ensure that there is no history of being a victim of DA
- Ongoing and recent research, especially by .T Woodhouse, identifies that 'perpetrators will use the threat of their own suicide as an act of coercive control'¹



Research

Domestic Abuse and Suicide

- More people in the UK are dying by suicide following domestic abuse than are being killed by a current or former partner
- 49.7% of all suicides in the UK are linked to domestic abuse (including perpetrator suicides)
- A quarter of Refuge clients reported feeling suicidal
- Primary risk factors to suicide in domestic abuse victims include 'any mental ill health' and 'a history of coercive and controlling behaviour'
- Most common form of suicide was by hanging
- Four key contributors to suicidality in a DA setting: physical and emotional/psychological pain (e.g. PTSD); Hopelessness; Lack of connectedness; Suicide capability



Jane Monckton Smith's Suicide Timeline

History of victim and perpetrator
History of intimate partner abuse

History of victim and perpetrator
Often form quickly and intensely

Relationship
Control and violence occur, creating fear

Disclosure
Victim discloses abuse, indication escalation

Help Seeking
Occurs when victim considers things have become more serious

Suicidal ideation
A sense that death is inevitable

Complete Entrapment
Feeling trapped, there is no escape

Suicide
Includes attempted suicide



Domestic Abuse Related Death Reviews



METHODOLOGY

Our sample was 8 Domestic Abuse Related Death Reviews (DARDRs) from Gloucestershire that were authored between 2019-2023

Reflexive Thematic Analysis was used to identify key themes in the reviews

All of the original codes and themes were sent to Gloucestershire's VAWG Policy and strategy lead as well as the collaborating author to corroborate the findings and check for bias.



INCLUSION CRITERIA

The inclusion criteria enabled the identification of themes that were present in the majority of the reviews, and are therefore the most commonly seen locally

The themes selected had to be recorded three or more times to be included in the final report

A code had to appear in three or more reviews to be included.



Background Information: Victims

Seven of the victims were female and one was male

Five of the female victims had children and had experienced periods of separation from them

All the victims had pre-existing mental health conditions

Five of the victims had experienced domestic abuse in previous relationships

Additional competing needs were identified in all the reviews



Background Information: (Alleged) Perpetrator

The panels discussed and agreed to the decision not to involve the alleged perpetrators in the review in all cases

All the (alleged) perpetrators were male

All the (alleged) perpetrators with female victims were older (n=7)

In most cases the (alleged) perpetrators were not convicted for domestic abuse offences against the victims

Four of the (alleged) perpetrators had alcohol or substance misuse issues

Two perpetrators had domestic abuse convictions related to previous relationships



The Deaths

All victims died by suicide or suspected suicide; the most frequent method of suicide was hanging (strangulation)

3	Hanging (Strangulation)
1	Suffocation
1	Burning
1	Poisoning
1	Fall and Fracture
1	Inconclusive



Domestic Abuse

This section of the DARDRs detailed the type of abuse experienced by victims. A theme which presented itself within this section that is not a type of abuse was **Siloed Professional Working**. It was identified in all of the reviews that when domestic abuse became an intersection of multiple disadvantage, victims felt less able to engage with singular agencies.

Coercive and Controlling Behaviour

- In six of the reviews, the (alleged) perpetrators would use their partners' mental health vulnerabilities as a means of exercising control.
- (Alleged) perpetrators would often use social isolation to isolate victims from their family and friends.

Economic Abuse

- In all eight of the reviews economic abuse was used by perpetrators to ensure their victim became financially dependent on them.
- In four of the reviews the (alleged) perpetrator had complete control over the victims' finances.

Physical Abuse

- In seven of the reviews physical abuse was recognised; this was either through self-disclosure or professional identification.
- In three of the reviews the victims had injuries that were inconsistent with their self-described injury

The extent of abuse featured in each of these cases was significant and feelings of fear or the belief that they are going to be killed can often increase victim suicidal ideation. Suicidal ideation is step six of Jane Monckton Smith's eight step Suicide Timeline, which is preceded by escalating levels of abuse following a speedy initial relationship.



Through the eyes of the victim

Methodological concerns were identified in Section 3 regarding the inconsistency of reporting styles that the DARDRs had. Subsequently, only six of the eight DARDRs had a 'through the eyes of the victim' section which accounted for the experiences of the victims.

Victims Felt Voiceless

- In four of the DARDRs, it was expressed that agencies could have done more to listen to the victims
- In the remaining two cases, there was no indication of how the victims' voice was used to influence the support that they were given
- Mental Health was treated in Isolation to other complex needs.

A Presence of Serious Violence

- In three of the reviews, serious violence was present during childhood and contributed to the victims having adverse childhood experiences
- For the period under review, four victims who experienced serious violence. This included: sexual violence, non-fatal strangulation, stalking and grievous bodily harm (GBH).



Agency Involvement

This section was the biggest in all of the reviews, it revealed some opportunities for learning as well as highlighting positive practice.



A lack of professional curiosity



Missed opportunity for information sharing



A need for improved methods for professionals to make referrals on behalf of victims



Building trusted and positive relationships



Safety planning



Single Agency Recommendations

The following agencies featured and had subsequent recommendations in all eight of the reviews. Therefore, it was important for this report to highlight some of the learning that was suggested to these agencies who were consistent throughout all eight DARDRs.

Gloucestershire Constabulary

- Improving the standards of investigation which includes the quality of Vulnerability Identification Screening Tool (VIST)
- Specific training in relation to domestic abuse.

Housing

- Improved understanding of housing victims of domestic abuse and the intersecting needs that may be involved.
- Recognise cycles of homelessness amongst victims of abuse and that the response to homelessness for these victims is not purely a case of 'getting a roof over their head'

Gloucestershire Health and Care Foundation Trust

- It was recommended that GHC offer in-depth training to all frontline and supporting staff on Domestic Abuse and how to create safe environments for disclosure.
- Additionally, domestic abuse training was recommended alongside safeguarding training to understand how professionals can support victims if a disclosure is made.



Multi-agency recommendations

Throughout this analysis, it has been emphasised that a multi-agency response and co-ordinated support for victims is key, specifically where there are mental health issues..

Improved Professional Awareness of the Links Between DA and Suicide

The Domestic Abuse Local Partnership Board (DA LPB) should do more to increase the awareness of the links between DA and suicide, to which this report forms part of the response.

This includes the suggestion that domestic abuse should be explicitly referenced in the local suicide strategy due to the nature of suicidal ideation amongst victims

CSPs should play a larger role in promoting the links between DA and Suicide due to their multi-agency involvement

Improve the Evidence Base for Suicide and Domestic Abuse Locally

The need for this report was a recommendation in three of the most recent reviews, alongside calls for research and a greater evidence base regarding suicide and domestic abuse in six of the reviews.

An evidence base can be of additional support in commissioning services, for example the use of MHIDVAs was mentioned throughout a couple of the reviews as a solution to ensuring that multiple needs are being met.



Key Themes and Lessons

Mental Ill-Health as a Symptom of DA and not an Isolated Illness

- Mental ill-health treated in isolation does not address the full needs of victims of domestic abuse. Treating mental health, substance misuse and domestic abuse in isolation to each other, agencies are failing to recognise how they are all congruent of each other
- Research has highlighted that when victims do not recognise or understand domestic abuse, they are less likely to seek help which subsequently may lead to self-medication via substance misuse or even suicide

Recognised Multi-Agency Response for Multiple Disadvantage

- MARAC meetings took place within some of the reviews, although many of the victims in the DARDs were not deemed high risk and therefore did not qualify for a conference. It is recommended nationally that risk of death by suicide should be included within MARAC criteria for DA victims

Agencies need to Prioritise Safe Environments for Disclosure

- Creating safe environments for disclosure is a reoccurring theme throughout this analysis; it is specifically prevalent within healthcare settings. Research has highlighted that prior to accessing support, victims with mental health needs were far more likely to have visited health care settings



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Any Questions?

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Want to learn more?

The next **DARDR Learning Event** will take place on Thursday 9th July 2026, 13:00 – 14:00.

Join Safer Gloucestershire for the second of their Domestic Abuse Related Death Review Learning Events. This month, Jane Monckton-Smith will provide an input on how escalation of domestic abuse intersects with suicide and increased risk.

To book, please visit:

<https://buytickets.at/domesticabuserelateddeathreviewlearningevents>

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The Escalation of Domestic Abuse and how it relates to Suicide Risk

Thu 9 Jul 2026 1:00 PM - 2:00 PM BST

📍 Online, Teams

