Jeanette – DHR – Summary, Key Issues and Recommendations

This review examines the circumstances surrounding the death of Jeanette in July 2022. Although her death was recorded as natural causes, the review found strong evidence that Jeanette experienced coercive control and neglect by her adult child (the alleged perpetrator) after her husband's death. These behaviours included isolation, deprivation of medical care, and psychological abuse.

Key Issues

- Missed Safeguarding Opportunities: Agencies relied on Jeanette's consent despite escalating risk; safeguarding referrals were delayed or not made.
- Failure to Recognise Domestic Abuse: Coercive control and neglect within a parent–adult child dynamic were not consistently identified as domestic abuse.
- Mental Capacity and Coercion: Lack of assessment of how coercive control impacted Jeanette's decision-making; poor documentation of capacity assessments.
- Mental Health Pathways: No clear diagnosis or support for the alleged perpetrator despite repeated concerns; lack of use of non-consenting pathways.
- Information Sharing Gaps: Agencies worked in silos; safeguarding concerns were not escalated or revisited after case closures.
- Risk Assessment Failures: No DASH completed; absence of MARAC referral despite repeat incidents and escalating harm.
- Community and Family Barriers: Family concerns were not acted upon; community lacked awareness of how to report safeguarding concerns.
- Professional Practice Gaps: Limited cultural competence; lack of curiosity about Jeanette's reluctance to engage; case closure by IDVA without full risk assessment.

Recommendations

- Safeguarding Practice: Ensure timely referrals, clarity on sharing information without consent, and recognition of coercive control as domestic abuse.
- Training: Refresh training for all professionals on domestic abuse in familial relationships, coercive control, and impact on mental capacity.
- Mental Health Pathways: Improve awareness of assessment routes for consenting and non-consenting individuals; consider risk posed by untreated mental illness.
- Carer Assessments: Ensure informal carers are assessed for capability and support needs; signpost to carer's assessments.
- Multi-Agency Coordination: Strengthen processes for joint risk assessment and holistic safeguarding plans; use MARM and MARAC appropriately.
- IDVA Practice: Audit case management; ensure safe contact methods and managerial oversight; treat non-engagement as a risk factor.
- Community Awareness: Undertake communications to empower families and communities to report concerns confidently and safely.
- Police Practice: Reinforce evidence-led investigations and positive action even when victims are reluctant; review DASH use for non-intimate abuse cases.

Link to full review: Domestic Abuse Related Death Review - Fenland District Council