NICKI DOMESTIC HOMICIDE REVIEW PROFESSIONALS' BRIEFING

DHR 14 MARCH 2022

WHAT IS A DOMESTIC HOMICIDE REVIEW (DHR)?

The Domestic Violence, Crime and Victims Act (2004) defines a Domestic Homicide Review as 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 either:

- a person to whom they were related or with whom they were or had been in an intimate personal relationship, or
- a member of the same household.

DHRs are held with a view to identifying the lessons to be learnt from the death.

DHRs are NOT inquiries into how the victim died or to find out who is to blame; that is a matter for coroners and criminal courts.

*not their real names. Pseudonyms have been used to protect the identities of those involved in this DHR.

INTRODUCTION

Nicki* tragically died as a result of suicide in 2017. Nicki was in a relationship with Jack* for the six months prior to her death. After her death, information came to light that suggested Nicki may have been a victim of domestic abuse in this relationship, however this was never confirmed. Nicki had very limited contact with agencies throughout her life.

WHY DID A DHR TAKE PLACE?

After Nicki's death, information came to the attention of the police that suggested she may have been the victim of controlling and coercive behaviour from Jack, and this may have played a part in her suicide. The alleged domestic abuse was never confirmed and was subsequently denied by Jack when spoken to as part of the review. There has been no criminal investigation or proceedings arising out of Nicki's death.

The Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews states that where a victim took their own life (suicide) and the circumstances give rise to concern, a domestic homicide review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

DHR PROCESS

The Safer Bristol Partnership (now part of the Keeping Bristol Safe Partnership) commissioned a DHR in early 2018. An Independent Chair, Ian Kennedy was appointed to lead the DHR and a review panel was formed with representatives from the following agencies:

- Avon and Somerset Police
- Bristol City Council Housing and Landlord Services
- Bristol City Council Public Health
- National Probation Service
- Nextlink (Domestic Abuse Services Provider)

Given the lack of information held by any agency, significant effort was put in to engaging with Nicki's family and friends to help understand her circumstances fully. Unfortunately, it was not possible to obtain any information from the family but Nicki's friends and her previous partner Jack, did contribute to the review.

BACKGROUND INFORMATION

- Nicki was a woman in her early 30's.
- She was born outside of the UK and moved to England with her mother when she was a child.
- She had lived in Bristol since her mid-20s.
- She was described as an outgoing but private individual. She had few close friends.
- She worked mostly on a 'cash-in-hand' basis and there were few official records of her in the UK. She was in this country legally, but she had little or no involvement with agencies locally and was not registered with a GP.
- In the six months prior to her death, she had been in an 'on and off' relationship with Jack.
- In the months leading up to her death, Nicki came to the attention of the police on one occasion. Nicki attended Jack's house when they had split up temporarily, and caused a disturbance. The police were called by Jack, though at his request they did not speak to Nicki. The police gave Jack suitable advice and closed the incident. The approach was appropriate and properly addressed based on the wishes of her partner.
- This one incident involving the police is the only record that any agencies have involving Nicki.
- According to her partner and close friends, Nicki's mental health had suffered at different times in the months before her death however there was no indication that she was going to take her own life. There was nothing identified that may have triggered an intervention by any agencies and brought about a different outcome for Nicki.

CONCLUSIONS FROM THE REVIEW

Whilst there has been some learning for individuals and organisations highlighted during the review, it all relates to actions post Nicki's death.

Her death was not foreseeable by any agency and she had no contact with any agency prior to her death.

It was appropriate to consider whether more could have been done to raise awareness of, or make services available to Nicki. Friends did advise her to seek help for her mental health which shows she was aware of what services were available. Unfortunately, this did not lead to her contacting or registering with a GP.

As no domestic abuse was confirmed in the relationship it has not been possible to identify how she could have been encouraged to seek help from domestic abuse services.

RECOMMENDATIONS

Due to the absence of any agency involvement, no multi-agency recommendations have been identified as a result of this review.

The police reflected that after Nicki died, there was too much of a focus on how she died with little consideration of why. Avon and Somerset Police have made changes to how sudden deaths are investigated to ensure that the possibility of domestic abuse is considered in any such future suicides so that appropriate action can be taken.

SUPPORT SERVICES

Domestic Abuse - If you or someone you know is experiencing any type of abuse, there is support available. Visit the **KBSP website** for information about services that can provide support. There is support available to those experiencing abuse, friends and family, as well as support for those who are concerned that their behaviour has become abusive and want to change.

Mental Health - If you, or someone you know needs support with mental health, there is support available. Find information about services that can provide support on the **KBSP website.**