minute briefing:

# Domestic Homicide Review into the death of 'Edie', 2021

**Edie's life**

Edie's and Ricky's relationship started about 12 months prior to their tragic deaths. Edie had been a victim of three violent and abusive men prior to this relationship and had young children who were in the care of their grandparent.

Edie's GP referred her to a local counselling service because of the impact of stress on her emotional and psychological health relating to the ongoing prosecution of a previous partner and contact with her children. The referral was declined due to criminal and Family Court proceedings being in progress.

On multiple occasions Ricky assaulted Edie and damaged her property and, although arrested, broke his bail conditions to visit Edie and to send threatening text messages. Ricky was remanded to prison on charges relating to theft and criminal damage but the prison was not aware that he had also been charged with assaulting Edie or that there was a history of domestic abuse. Ricky was able to maintain contact with Edie by phone.

Ricky died by suicide and, a week later, Edie also died by suicide.

**Purpose of the review**

The review was commissioned by North East Lincolnshire Community Safety Partnership on receiving notification of the death of Edie in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

The Community Safety Partnership has a legal duty to conduct a multi-agency review to understand where public services may improve their responses to similar situations in the future. The review does not consider who is to blame but seeks to support the prevention of similar incidents from happening in the future.

**Good practice identified**

The support worker from Women's Aid continued to make calls to Edie even when Edie declined conversations or didn't pick up calls when Covid prevented home visits.

Edie had contact and support from two IDVAs at different times which provided a better opportunity for understanding her circumstances and relationship-building.

The mental health nurse at the GP provided regular opportunities for Edie to talk about the stressors in her life. The nurse referred Edie to the Blue Door.

The night shelter provided a safe refuge for Ricky and attempted to signpost him to services.

The probation officer supervising Ricky made sure Edie was aware of Ricky's long history of alcohol abuse and the implications for her children.

A police community support officer was allocated to make regular contact with Edie as a higher-risk victim of domestic abuse.

**Key learning points**

- Individual DASH risk assessments should be supported by other risk markers and motivation, including controlling behaviour and economic abuse, which may provide clearer evidence of escalation.
- Professionals should be curious about new relationships where there is a previous history of domestic abuse.
- It is not enough for healthcare staff to have an awareness of domestic abuse; healthcare should have integrated pathways with domestic abuse services.
- Separation marks a potential escalation of risk. Remand to prison requires an agreed safety plan with good information passed to the court liaison services about domestic abuse, including victim contact details to be included in prohibited lists.
- Research suggests that men who seek control in their intimate relationships can be dependent on the woman for their sense of identity. Ricky showed this dependency together with a history of depression and threats of self-harm and these should have been seen as significant risk markers for him. Prison health services and GPs should liaise to ensure vulnerability information is shared.
- Professionals should understand the barriers for women in disclosing abuse, escaping abuse and engaging with help. They are robbed of their ability to make choices.

**Next steps**

- Information is shared between Police and Probation on any history of domestic abuse. This will be further enhanced by providing Probation with direct access for Police checks.
- Prison staff have been trained in dealing with individuals arriving into custody who may have domestic abuse markers on their files. A 'day two' check has been introduced to ensure all risk markers are captured when prisoners arrive into custody, including document checks and alerts added to electronic systems.
- Two 'Primary Care Safeguarding Nurses' have been recruited to improve safeguarding practice across primary care. Weekly safeguarding drop ins are now running and provide support and advice to Primary Care staff.
- A 'was not brought' policy is being developed to ensure there is appropriate follow up for children and vulnerable adults who do not attend appointments.
- Flagging is now used to discretely and consistently code the health records of patients at risk of self-harm. Where adults at risk are open to services, details are recorded of other professionals involved in their care such as IDVA or social worker.
- A national procedure has been established by HMPP to prevent unwanted prisoner contact. A non-contact request can be made by anyone on behalf of the victim, in the case of domestic abuse, even without their consent. Awareness raising has been disseminated within HMPP and Humberside Police.
- Training and awareness raising continues on an ongoing basis to ensure practitioners have the confidence and practical skills needs to respond to victims of domestic abuse and to complete the DASH risk assessment giving consideration to repeat incidents. Cases are dip-sampled to check sufficient information is captured.
- We Are With You drug and alcohol treatment service is providing coaching to staff to ensure they recognise and respond appropriately to changing circumstances that may affect risk.
- National best practice is being explored regarding provision to focus on repeat victims and perpetrator interventions to break the cycle.

The full overview report, action plan, and a copy of the quality assurance letter from the Home Office can be found at: https://www.safernel.co.uk/crime-and-staying-safe/domestic-homicide-review/