

Safer Somerset Partnership

Domestic Homicide Review

Report into the death of Nicole

Date of death: May 2023

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Domestic Homicide Review Overview Report

Safer Somerset Partnership

Report into the death of Nicole
May 2023

Author – Dr Shonagh Dillon, LLB, DCrimJ

November 2025

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Glossary

ASP – Avon and Somerset Police

BRAG – Blue, Red, Amber, Green

CCB – Coercive and Controlling Behaviour

CPD – Continuing Professional Development

CMHT – Community Mental Health Team

CPS – Crown Prosecution Service

CSC - Children's Social Care

CSP – Community Safety Partnership

DA – Domestic Abuse

DASH – Domestic Abuse, Stalking and Honour Based Violence

DHR – Domestic Homicide Review

ED – Emergency Department

EDT – Emergency Duty Team

GP – General Practitioner

HO – Home Office

HTT – Home Treatment Team

ICB – Integrated Care Board

IMR – Individual Management Review

LSU – Local Safeguarding Unit

MARAC – Multi-Agency Risk Assessment Conference

NFA – No further Action

NHS – National Health Service

PHN – Public Health Nursing

PSED – Public Sector Equality Duty

SFT – Somerset NHS Foundation Trust

SSP – Safer Somerset Partnership

SW – Social Worker

SWAST – South Western Ambulance Service

TOR – Terms of Reference

Domestic Homicide Review Overview Report into the death of Nicole, May 2023

Preface

The independent author, Domestic Homicide Review (DHR) panel and the Safer Somerset Partnership wish to offer their deepest condolences to everyone who was affected by Nicole's¹ death. We extend our further thanks to those who knew Nicole and contributed to this review, their generosity in doing so, considering their loss, is greatly appreciated.

In addition to this the author and the panel would like to extend our thanks to all professionals who responded to the Individual Management Reviews (IMR), their time and effort enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincere thanks to the panel members for their professionalism and the considered manner in which they approached this review.

Pen Portrait and Tribute

Nicole's friend provided valuable insight into who she was as a person. Nicole was deeply committed to her work and devoted to her children, whom she adored. Although the review panel was unable to speak with Nicole's family and was therefore unable to develop a full pen portrait, the tribute shared by her friend offers a heartfelt reflection of Nicole's character, the love she inspired in those around her, and the profound loss felt following her death.

She was such a beautiful, beautiful woman, just a bundle of fun. Warm, energetic, empathic, with the kindest nature. That kindness made her vulnerable, though. People can exploit that kind of goodness.

She absolutely adored her children. I know people say that about mothers, but with her, it was different. They were her world. She was a fun mum, always cooking, always had friends around. Her house was an open door. That's who she was, so warm, so welcoming.

She was laid back in many ways, letting her children be themselves, but she knew when to be firm. Nicole made sure they were well looked after, even while juggling life. She was my friend, and I miss her every day.

¹ Not her real name

1. Introduction and Background

1.1 This review will examine the circumstances surrounding the death of Nicole, aged 43. Nicole's death is believed to be as a result of natural causes. Self-neglect due to substance use was explored within the initial referral for the DHR and in subsequent considerations by the CSP. Most notably, domestic abuse was a concurrent factor in her relationship with her ex-partner until the point of her death.

The combined impact of long-term domestic abuse and coercive and controlling behaviour on Nicole's mental health and substance use is the context within which the panel analysed her tragic death.

1.2 Domestic Homicide Review's (DHRs) came into force on the 13th of April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be 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) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death².

1.3 The purpose of a DHR is to:

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

² Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

f) highlight good practice

2. Timescales

This report of a death, where domestic abuse was identified, analyses the involvement and responses afforded to Nicole, who was a resident in Somerset at the point of her death in May 2023.

The review will consider agency contact with Nicole for the period of:

- November 2020 to May 2023

This time frame was agreed to be appropriate by all panel members in April 2025.

Public Health Nursing had a discussion with Somerset NHS Foundation Trust Domestic Abuse Lead and established that no DHR referral has been submitted by other agencies. This led to further discussion with Somerset DHR coordinator and agreement that the decision should be made by DHR panel around whether or not this meets threshold for DHR. There is therefore a noted delay between Nicole's death and the decision to undertake a DHR.

The referral from the Somerset Public Health Nursing Safeguarding Service was sent to the CSP on the 02/05/2024. The decision to undertake a DHR was made by the Somerset Safer Partnership on 21/07/2024.

The Home Office was subsequently informed on 31st July 2024. There was a delay prior to commissioning the review in February 2025 due to a lack of available resources. Once resources were secured, a competitive process ensued, and Dr Shonagh Dillon was appointed to undertake the role of independent author and chair to the panel, and the DHR panel was convened. The panel members remained consistent throughout the review and met on the following dates:

- April 2025
- July 2025
- September 2025

2.1 The overview report and executive summary were presented to the Somerset Safer Partnership (SSP) for approval on 22/11/2025 and submitted to the Home Office on 22/12/2025. The report was considered by the Home Office Quality Assurance Panel on 20/05/2026 and the QA subsequently wrote to the CSP to approve publication prior to minor amendments on 06/07/2026. The Home Office Quality Assurance letter and response to suggested amendments is available in appendix B.

3. Confidentiality

The Individual Management Reviews (IMR) will not be published but the DHR report will be made public.

The contents of this report are anonymised to protect the identity of the deceased, family, friends, staff, and others to comply with the Data Protection Act 2018³.

The panel has applied the Home Office guidance and has given the pseudonyms identified above to the offender and the victim. It is hoped this humanises the review process and eases the reading of the report. Nicole's family were not involved in the review thus there was no available option to ask them about the pseudonyms chosen. However, Nicole's friend was happy with the name chosen for her.

In addition, the panel were not aware of any issue with the pseudonym chosen for Nicole's ex-partner.

4. Methodology and Terms of Reference

4.1 Following the decision to conduct this DHR, the panel met to discuss the involvement of agencies with Nicole and the known domestic abuse risk factors from her ex-partner Harry⁴. Expert analysis was provided to the panel from leading professionals in suicide prevention and substance use. Their views were garnered at the end of the panel analysis, and they provided focused advice in relation to their expertise and the impact this may have had on Nicole during her interactions with agencies.

Statutory and voluntary sector agencies were asked to return a chronology and or IMR of their involvement to help the panel understand and analyse any interactions agencies had with Nicole during the specified review period.

The following data was requested:

- Avon and Somerset Police (ASP) - chronology & IMR
- NHS Somerset Integrated Care Board (ICB) - chronology & IMR
- Somerset Public Health Nursing (PHN) - chronology & IMR
- Somerset NHS Foundation Trust (SFT) - chronology & IMR
- South Western Ambulance Service NHS Foundation Trust (SWAST) - chronology & IMR
- Somerset Children's Social Care (CSC) - chronology & IMR
- Housing Options & Homelessness, Somerset Council (formerly Sedgemoor District Council)- chronology & IMR
- Somerset Domestic Abuse Service – chronology only

³ <https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted>

⁴ Not his real name

The panel made the collective decision to request chronology data without an IMR from Somerset Domestic Abuse Service, owing to the fact they had only one referral for her a day prior to her death, and no direct contact.

4.2 Nicole was not referred under the Care Act 2014⁵ for self-neglect – and the panel make no comment or pronouncement that she should have been. Self-neglect is complex; however, the review analysed the issues surrounding potential self-neglect for victims of domestic abuse and the intersecting needs that may present in these individuals.

Self-neglect is an extreme lack of self-care, it is sometimes associated with hoarding and may be a result of other issues such as addictions⁶.

The review author commends the Safer Somerset Partnership for commissioning this review. The potential links between self-neglect, coercive and controlling behaviour, trauma, substance use, and increased vulnerability represent an emerging and important area of safeguarding practice. The review panel explored these interrelated issues in greater detail in Section 13.4 and has made recommendations aimed at strengthening learning and informing future safeguarding practice at both local and national levels.

4.3 The Terms of Reference guidance set out the purpose and the scope of the review, and the panel focused on the following questions for analysis:

Key Lines of Inquiry DHR

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers the victim faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.
 - In regard to children and any potential impact this had ensuring the safeguarding of any children during the review.
- Examine the events leading up to the incident, including a chronology of the events in question.

⁵ <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

⁶ <https://www.scie.org.uk/self-neglect/at-a-glance/>

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults, particularly policy and practice in response to evidence of self-neglect.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
- Whether professionals explored or had adequate knowledge of the intersections of substance use, mental health and domestic abuse.

The authors of the IMRs are independent in accordance with the Home Office guidance⁷.

The full Terms of Reference are available in Appendix A of this report.

4.4 This report is based on:

- The combined chronologies of all agencies
- The findings and panel analysis of the IMRs
- Interactions with Nicole's friend and work colleagues

7

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DARDR-Statutory-Guidance-161206.pdf (Section 7)

The chronology is set out below (see section 12). Recommendations are presented in section 15 of the report. The panel have reflected and amended where they felt single agency actions needed further clarity.

The full recommended action plan is presented in section 16 of this report.

The conclusions and recommendations are the collective views of the Panel, which has the responsibility, through the participating agencies, for implementation of any improvement recommendations.

4.5 People involved in the DHR

Name	Age at time of death	Relationship with the victim	Ethnicity
Nicole	43	Victim	White British
Harry	41	Perpetrator	White British

Nicole had three children with Harry, and at the point of Nicole's death they were aged 17, 14 and 12. When Nicole sadly passed away, they were all residing with Harry.

5. Facts and background information

Nicole was a 43-year-old woman. Seven days prior to her death Nicole had a meeting with a housing officer from Homes in Somerset⁸ and Nicole had visible bruising. Nicole disclosed ongoing abuse from her ex-partner, Harry. Nicole felt her only way out was to die by suicide, and she told the housing officer she had attempted to take her life the week before because of the abuse.

Records show that Nicole and Harry had been separated for eight years but they had stayed in contact with each other due to their three children. Nicole informed the Community Mental Health Team (CMHT) in 2021 that the abuse had been ongoing for 17 years. Nicole explained she hadn't told a lot of people about what Harry had subjected her to over the years, but it is apparent through the data that she began to feel more able to disclose the abuse she had been subjected to by Harry during the latter months of her life. In May 2023 Nicole died suddenly by natural causes attributed to her ongoing alcohol related illnesses and evidence of potential self-neglect. May she rest in peace.

6. Involvement of Family and Friends

6.1 Victim

The CSP informed the family of the review and shared all relevant information including the Home Office leaflet. Subsequently the chair and author of the review wrote to Nicole's mum in June 2025 and again in September 2025, offering the chance

⁸ <https://www.homesinsomerset.org/>

to meet and discuss the review process and any input she would like to have in expressing her views about the domestic abuse Nicole was subjected to from Harry. The chair signposted Nicole's mum to Advocacy After Fatal Domestic Abuse⁹ to assist her independently if she wanted support. No response was received.

The police representative assisted the chair and author in reaching out to Nicole's boyfriend who was present at the time of her death. No response was received.

The panel observed the referral made by Nicole's employer in November 2020 and the chair and author reached out to them in August 2025. Nicole's employer and one of her work friends responded to the author and meetings were held online. Their views are reflected in section 13.5 of the review.

6.2 Perpetrator

The panel deliberated at length on whether to contact Harry. All three children still resided with him at the point of undertaking the review. There were tangible safeguarding concerns for one of Nicole's children raised by professionals at the panel and ultimately it was decided the best course of action would be to refrain from contacting Harry. Consideration was given to utilising safeguarding professionals as a mediator between the chair and the children, and discussions were held between the chair and relevant professionals outside the panel meetings.

Ultimately the paramount decision was based on the known safeguarding concerns but in addition the panel reflected that Harry had never been spoken to by professionals before about his abuse of Nicole and the review would be the first time this discussion was approached with him. Given that Nicole died of natural causes the panel considered the impact on wider family dynamics, and risks associated for other third parties.

Whilst the panel acknowledges best practice is always to reach out to children and or offenders, the panel wait keenly for the new Home Office guidance on DHRs – many reviews complicate the contact with alleged perpetrators and other family members because of the circumstances of the victim's death – this ultimately means panels are left to assess all information available and make the best decision for victims loved ones.

The review is therefore limited in the perspective of the perpetrator and the children, and whilst this is regrettable after speaking to Nicole's friend the panel are confident this was the right decision for all involved.

7. Independence

The chair and author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

⁹ <https://aafda.org.uk/>

Dr Dillon is a Home Office accredited DHR chair and has over three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Nicole or Harry.

8. Domestic Homicide Review Panel

The DHR panel consisted of the following agencies and professionals:

Panel Members
Chair and Author – Dr Shonagh Dillon, LLB, DCrimJ
Avon and Somerset Constabulary
Somerset Council - Community Safety Team (on behalf of Safer Somerset Partnership)
Somerset Council - Children's Social Care
NHS Somerset Integrated Care Board
Somerset Council - Housing
Homes in Somerset
Somerset NHS Foundation Trust
Somerset Council - Public Health Suicide Prevention
Somerset Domestic Abuse Service
South Western Ambulance Service
Somerset Drugs and Alcohol Service

9. Parallel Reviews and Processes

The postmortem revealed the cause of death as: 1a Haemorrhage from Oesophageal Varices, 1b Cirrhosis, 1c Alcohol Use Disorder. As this was a natural cause death, no inquest followed.

There are no other parallel reviews in this case.

10. Equality and Diversity

Relevant TOR point: Determine if there were any barriers the victim faced in both reporting domestic abuse and accessing services. This should also be explored:

- *Against the Equality Act 2010's protected characteristics.*

10.1 The Equality Act 2010 defines the following as protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

All the protected characteristics have been considered throughout this process with mental health being addressed under 'disability'. Services must adhere to the Public Sector Equality Duty (PSED)¹⁰ and have due regard to the protected characteristics of individuals in order to harmonise equalities and foster good relations.

There are generally three aims¹¹ under the PSED and these involve:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Both Nicole and Harry were White British, and heterosexual, the data did not reveal that either associated with any particular religion.

Nicole's experiences cannot be understood through a single lens. The intersection of her sex, experiences of domestic abuse, trauma, mental ill-health, substance use, and indicators of self-neglect created a complex set of vulnerabilities which heightened her risk and may have influenced how professionals understood, assessed and responded to her circumstances.

The following protected characteristics have been considered in the analysis of the review:

10.2 Sex - Worldwide, over a quarter (27%) of women aged 15–49 years who have been in a relationship report that they have been subjected to some form of physical and/or sexual violence by their intimate partner¹². Nicole shares many of the same experiences and characteristics as the other women who are subjected to domestic abuse - the overriding factor they all have in common is their biological sex. There was nothing to suggest that Nicole was discriminated against because of her sex during the review data but given the commonality of sex-based discrimination when it comes

¹⁰ <https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty>

¹¹ <https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty>

¹²

https://books.google.co.uk/books?hl=en&lr=&id=8sVqEAAAQBAJ&oi=fnd&pg=PR6&ots=bbiOx6Vti6&sig=8hq4EBtcVp_7yTx4_5rci_8zlf4&redir_esc=y#v=onepage&q&f=false

to domestic violence and abuse, referrals and signposting to domestic abuse support agencies should be routine and repetitive, the data revealed this was not the case for Nicole and this was acknowledged throughout the IMR analysis, the panel discussions and the recommendations offered by organisations.

10.3 Disability/ Mental health - Protected characteristics and the discrimination people face often intersect. Nicole's presenting issues could be described as multiple and complex, when taken into context of a victim of abuse who also intermittently used substances and had mental health issues. The relationship between suicidal ideation and domestic abuse is a growing area of research and new data reveals that women who suffer domestic abuse are three times more likely to take their own life and or use self-harm as a coping mechanism¹³. Research¹⁴ reveals that death rates from suicide are consistently higher for men, and thus many interventions to reduce the suicide rate amongst populations are aimed at men. Although this work should not be undermined, it means that women's experience of suicidal ideation is often side-lined. Given that women are significantly more likely than men to attempt suicide¹⁵.

Nicole's death was ultimately not because of suicide, but she died suddenly as a result of alcohol related health issues – the panel noted that Nicole's death would have been painful and traumatic. The panel did highlight there may have been some unconscious bias relating to Nicole, and there was an emphasis on her substance use and limited challenge of Harry's abusive behaviours, this is further explored in section 13.4. In addition, the issue of self-neglect was keenly observed within the analysis which raised more questions than answers in respect of victims of domestic abuse, these findings are reflected within the recommendations in section 15.

11. Dissemination

11.1 Whilst it is essential to share key issues with agencies and organisations involved in this DHR, this report will not be disseminated until clearance has been received from the Home Office quality assurance group.

11.2 Nicole's family will be informed of the finalisation of the review and offered an opportunity to read the review prior to publication. In addition, a copy of the review will be sent to Nicole's employer.

11.3 Once clearance has been approved by the Home Office quality assurance group, the dissemination of the overview report will be published on the Somerset Survivors website and will be widely disseminated including, but not limited to:

- Members of the Community Safety Partnership
- Somerset Domestic Abuse Board
- Avon and Somerset Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- Somerset Safeguarding Children Partnership

¹³ <https://www.theguardian.com/society/2023/feb/22/women-who-suffer-domestic-abuse-three-times-as-likely-to-attempt-suicide#:~:text=Victims%20of%20abuse%20by%20a,risk%20of%20having%20suicidal%20thoughts.>

¹⁴ <https://journals.sagepub.com/doi/full/10.1177/0269758018824160>

¹⁵ <https://journals.sagepub.com/doi/full/10.1177/0269758018824160#bibr15-0269758018824160>

- Somerset Safeguarding Adults Board

The Somerset Domestic Abuse Board will be responsible for monitoring the implementation of recommendations. A working action plan reflects how learning will be monitored and put into practice over time.

12. Chronology

Relevant TOR Point: Examine the events leading up to the incident, including a chronology of the events in question.

12.1.1 This section is not intended to replicate the combined chronology of agencies in full, due to the large amount of data produced by agencies within the timeline period the following information represents the significant events relating to Nicole and Harry.

References to the assessment of risk for domestic abuse cases include the Domestic Abuse Stalking and Honour Based Violence¹⁶ (DASH) risk checklist.

There are incidents outside the timeline period which are of note to the review. Between 2016-2019 - Harry was involved in domestic abuse incidents including assault and harassment with two other partners as well as Nicole.

Harry is recorded by ASP as being the victim and perpetrator, and there are also reports of drug offences and harassment by Harry towards other third parties.

Multi-Agency Risk Assessment Conference (MARAC) summary within timeline period:

- 2021 - October (Harry victim, ex-partner 1 perpetrator); November (Harry perpetrator, ex-partner 1 victim).
- 2022 – February (Harry perpetrator, ex-partner 1 victim); September (Harry listed as victim and perpetrator and victim, ex-partner 1 victim).
- 2023 - January (Harry victim, ex-partner 1 perpetrator); March x 2 (Harry perpetrator, ex-partner 1 victim); May – after Nicole’s death (Harry perpetrator, Nicole victim)

November 2020:

- 12.1.2 Nicole had two appointments with her GP in November 2020 to discuss anti-depressants. She reports feeling better in a follow up meeting with her GP in the latter part of November, commenting that she has good days and bad days, but she feels better when she is at work. Nicole discloses she is not sleeping well and attributes this to being a single mum with two small children, she agrees to follow up with her GP if her symptoms worsen.

¹⁶

<https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf>

- 12.1.3 ASP receives a call from the Human Resources department of Nicole's employer (a Higher Education setting) in November 2020. They are concerned Nicole is a victim of domestic abuse (DA) and note Harry is the alleged perpetrator. Nicole had told her work that she had called ASP a few days prior because of an incident of DA from Harry, and she hadn't heard back from them. ASP have no record of this call. The employer wanted to follow up as they were worried about Nicole. The record from ASP details the following:

Officers spoke to Nicole at home (the children were with Harry at his property) who repeatedly denied any domestic abuse had occurred. She expressed annoyance that her workplace had made the report. Nicole explained she had fallen over in the bath which accounted for the bruising on the back of her arm and advised it was witnessed by her daughter. Bruising observed by officers was consistent with explanation. Nicole did disclose non recent emotional and mental abuse by Harry whilst they were in a relationship (she advised they had been divorced for 5 years and were living separately). She advised officers their only contact now was in relation to the children. She advised she had no concern for the children's safety. Nicole's last contact with Harry was when she picked up the children from his flat in the previous week.

ASP did not complete a DASH at this time and consequently no internal referral was made to the police Lighthouse Safeguarding Unit¹⁷ (LSU).

December 2020

- 12.1.4 Eight days later Nicole called her GP reporting having fallen in the shower explaining she was heavily bruised with possible fractured ribs. Nicole had been taking pain medication at home but was prescribed codeine by the GP to assist her. No routine screening of DA recorded.

February to March 2021

- 12.1.5 During February Nicole attended hospital after GP advice. Nicole had a tight chest and was struggling with her breathing. The discharge advice received by the GP from the hospital noted Nicole had a cyst on her pancreas.
- 12.1.6 In March 2021 Nicole has a telephone consultation with her GP where she disclosed, she is struggling with her mental health. Nicole states she has been drinking more but is trying to decrease her alcohol intake. Nicole describes pressure from her workplace, and she has thought about suicide but states she won't do this "*because of the children*". Nicole's mum is supporting her. The GP signs Nicole off work for two weeks and undertakes a review of her anti-depressants.

¹⁷ The LSU offers an enhanced service to vulnerable, intimidated or persistently targeted victims of crime and anti-social behaviour as well as to victims of serious crime.

- 12.1.7 At a follow up appointment with her GP Nicole says she doesn't feel better or worse. Nicole discloses drinking a bottle of wine a night, but never to the stage where she is drunk. No record of discussion regard to alcohol affecting impact of anti-depressants. The GP asks about the effect on the children and Nicole says she feels able to look after them. Nicole has contacted a counsellor via her work and is trying to reduce her alcohol intake. The GP signposts Nicole to Somerset Drug and Alcohol Service, and Nicole explains she would like to try counselling first.
- 12.1.8 The GP followed up with Nicole one week later and she disclosed she had been alcohol free for 5 days. Nicole was still struggling with sleep, and the GP prescribed one week of sleeping medication. The plan was to follow up with Nicole in 6 days. Subsequently the GP surgery called Nicole three times but could not get hold of her for the planned follow up appointment.

April 2021

- 12.1.9 Nicole's mum spoke with the GP and explained that Nicole was sitting in bed all day, and mum was currently caring for the children. Nicole's mum said she felt Nicole was hiding how she was feeling, and her mum had prevented her from taking an overdose. Nicole's mum explained that the stresses Nicole was under were related to Harry and work stress. A mental health crisis team referral was made.
- 12.1.10 At the assessment with the crisis team Nicole discloses she has been subject to coercive and controlling behaviour (CCB) from her ex-husband Harry for 17 years. Nicole explains she is very frightened of Harry as his father is a well know drug dealer in the area and she fears he could kill her at any time or come into the house and smash it up. Nicole accepted the contact details for Somerset Domestic Abuse Service and declined any further support from mental health services. The disclosure was not coded as domestic abuse on the primary care records. No record of a discussion regarding alcohol being used as a coping mechanism and the impact on mental health.
- 12.1.11 Later in April there was a report to the police about a neighbour dispute at Nicole's address. Harry was angry and had attended the property where words were exchanged between Harry and the neighbour. When the police attended Harry had already left. A referral was made to the neighbourhood policing team to monitor the tension between the neighbours.
- 12.1.12 A few days after this there was a third-party report of a domestic abuse incident on Harry's partner at the time (referred to as ex-partner 1). Ex-partner 1 was spoken to and a DASH completed, with the grading attributed as medium risk. Ex-partner 1 did not want to proceed with a complaint and the incident was closed with no further action.

May to June 2021

- 12.1.13 During May and June Nicole had routine appointments for the COVID19 jab and follow up appointments on the cyst on her pancreas. No record of targeted clinical inquiry of DA from the GP.
- 12.1.14 In late June Nicole spoke to her GP and explained she had been made redundant, and this was causing her stress, so she requested a sick certificate. Nicole had been alcohol free, but the redundancy led to her drinking again. Nicole said she will stop drinking again now she has the sick certificate and agreed to contact the GP if she needed further support.

October 2021

- 12.1.15 A domestic incident was reported to the police between Harry and ex-partner 1. Harry was listed as the victim in this incident, and a DASH was completed where the risk attributed was high. The children were at the property (with other children as there was a sleep over). LSU made referrals to Children's Social Care and Safeguarding in Education. Harry was also referred to Somerset Domestic Abuse Services and MARAC.

November 2021

- 12.1.16 Nicole had a telephone consultation with her GP where she explained she was dealing with the loss of her job and the job centre suggested she should be given a sick note for stress at home. Nicole stated ex-partner 1 had thrown her children out of Harry's home at 4am and children's social care (CSC) were now involved. Nicole said she was drinking sometimes but only in the evening. The GP gave her a 2-week sick note and Nicole said she said she was applying for benefits and things were currently financially difficult.

December 2021

- 12.1.17 In December 2021 ASP were called to two more DA incidents between Harry and ex-partner 1. The first of these ASP attended and Harry had a visible injury to his neck. Ex-partner 1 made a counter allegation at this incident, and she was noted to be intoxicated. Ex-partner 1 was arrested. LSU made a further referral to Somerset Domestic Abuse Service and updated MARAC on the further incident.
- 12.1.18 A few days later ex-partner 1 called ASP to say that Harry was at her address. She was intoxicated and police ascertained that ex-partner 1 was not at her address and could therefore not confirm Harry's presence. All further attempts to contact ex-partner 1 were not achieved and thus no referral was able to be made to Somerset Domestic Abuse Service.

January to February 2022

- 12.1.19 During this time 3 incidents of DA were reported to police where Harry was listed as the perpetrator of ex-partner 1. The incidents included harassment and malicious communication. MARAC referral and Somerset Domestic Abuse Service was offered to ex-partner 1. The case was NFA due to ex-partner 1 not responding to further contact from ASP.

March 2022

- 12.1.20 Harry approached housing options in March 2022. He disclosed the DA he had been subjected to from ex-partner 1 and explained he was not working due to mental health issues. Harry explained he had three children with Nicole who he has 2-3 nights a week and he is currently living with his brother and friends. Housing advises Harry to get a solicitor's letter to support the need for a 2-bed housing allocation.
- 12.1.21 During March 2022 there are a further 5 contacts with regards to Harry's housing situation. Harry is allocated a private rental property in the latter part of March 2022, and the homeless duty is discharged.

June to July 2022

- 12.1.22 In June Harry reports ex-partner 1 to police for making threats to one of his children via malicious communication. The incident was later closed with no further action.
- 12.1.23 In July 2022 SWAST receive a call from Harry stating he took an overdose and regretted this. Harry explains he had "*been struggling with life for a few days*". After the overdose he started vomiting and his abdominal pain is getting worse. Harry is taken to hospital and bloods are taken.
- 12.1.24 Later in July Harry calls housing again and asks for a bigger property for his children. Housing explain he will need to fund this himself.
- 12.1.25 In July Nicole has 3 routine appointments with the GP. These are unrelated to DA, mental health, and substance use.
- 12.1.26 Harry contacts police in July 2022 explaining he is experiencing harassment from another ex-partner (referred to as ex-partner 2). The case is later closed with no further action.

August 2022

- 12.1.27 In August Harry hands his tenancy back due to mental health issues and he is now living with his dad.

September 2022

- 12.1.28 In September 2022 Nicole attends the hospital with abdominal distention. Nicole receives a diagnosis of alcoholic liver disease and oesophageal varices, (commonly known as cirrhosis of the liver). The GP signposts to Somerset Drug and Alcohol Services.
- 12.1.29 ASP receive reports regarding DA between Harry and ex-partner 1. Two incidents of criminal damage and one of malicious communication are reported and Harry is noted as a victim. Ex-partner 1 also discloses Harry slapped her to the face and grabbed her. Children are not present at these incidents. DASH risk assessments were completed and assessed Medium and High (with Harry as the victim), and Medium and Standard (with ex

partner 1 as the victim). LSU made referrals to Children's Social Care, Somerset Domestic Abuse Service and MARAC.

- 12.1.30 A police report was shared with children's social care (CSC) in September 2022 in relation to DA above. CSC meet with Harry and Nicole to discuss the safeguarding of the children. The children are aware they need to call Nicole if ex-partner 1 attends Harry's address whilst they are there. A safety plan is put in place with both Harry and Nicole agreeing to it. NFA taken by CSC at this stage.

October 2022

- 12.1.31 The GP continues to monitor Nicole's liver function and signs of improvement are noted. Attempts to contact Nicole directly are not responded to.

November 2022

- 12.1.32 In November 2022 Nicole contacts SWAST after taking an overdose. Nicole discloses she is having intrusive and suicidal thoughts. Nicole tells SWAST she was subjected to sexual abuse as a child and has been suffering DA from her ex-partner Harry. Nicole states this has had a detrimental effect on her mental health, and she explains she is alcohol dependent. SWAST refer Nicole for a mental health assessment. A DASH was completed by SWAST and shared with the GP.
- 12.1.33 The GP receive a letter from psychiatric liaison services after Nicole took an overdose. The records note Nicole disclosed historic and recent domestic abuse from ex-husband, and she described Harry badgering her, with continued psychologically abuse. Nicole explains that Harry denies abusing her saying that "*it is all in her head*". Psychiatric liaison referred Nicole to Open Mental Health and she was given contact details for Somerset Domestic Abuse Service and Somerset Drug and Alcohol Service, as well as Mindline Somerset¹⁸. Nicole did not attend the two appointments offered and attempts were made to contact between Nov 2022 and Feb 2023, but Open Mental Health were unable to make contact.
- 12.1.34 CSC received notification of the overdose from SWAST with reference to the DA she was being subjected to from Harry. CSC spoke to both Nicole and Harry. Nicole said she had experienced verbal abuse from Harry, but this was not ongoing. Nicole said she no longer felt suicidal and did not need additional support. Harry described Nicole as a "*fantastic mother*" and said he would help out more with the children. Education was updated and NFA was taken by CSC.
- 12.1.35 ASP also received the report regarding Nicole's overdose and disclosures of DA. An officer attended Nicole's address, and she denied there ever being any physical abuse, but disclosed verbal abuse from Harry. Nicole said she would use a third party to discuss the children with Harry if necessary. She also disclosed she was attending Alcoholics Anonymous

¹⁸ <https://www.mindinsomerset.org.uk/our-services/adult-one-to-one-support/mindline/>

(AA) meetings. A DASH was declined but completed by the officer and graded as standard. The case was later closed with no further action as no offences were disclosed. LSU notified Safeguarding in Education.

- 12.1.36 Public Health Nursing (PHN) received the information regarding the above from SWAST. PHN records state they will liaise with the children's school, but there are no further records to state the link between PHN and education was actioned.

January 2023

- 12.1.37 In January 2023 another incident of DA is reported to the police between Harry and ex-partner 1. Harry reports being a victim of assault and ex-partner 1 makes a counter-allegation. The incident is NFA, and both are referred to MARAC and Somerset Domestic Abuse Service. CSC are informed and they have a conversation with Harry and Nicole. The children were not present at the incident, and the previous safety plan is still in place. CSC are satisfied that no further actions are needed, and they inform education.
- 12.1.38 Nicole has a telephone consultation with her GP in mid-January – she talks about her recent suicide attempt and says she is experiencing depression. Nicole discloses she has financial issues due to the loss of her job and is a Fit Note¹⁹ is issued. A follow up appointment is made with Nicole's GP who knows her well.
- 12.1.39 Towards the end of January Nicole has a face-to-face appointment with her GP. She discloses depression and states she feels her ex-husband (Harry), caused her suicide attempt. Nicole says she drank alcohol a few weeks ago because of the ongoing DA she is being subjected to from Harry, she also discloses previous eating disorders and says she has lost weight. Nicole states her parents are supportive. The GP prescribes new antidepressants. There is no record of signposting or referral to DA support.
- 12.1.40 At the end of January, a report is made to police by ex-partner 1 disclosing harassment from Harry, who is posting videos and contacting her repeatedly. The case is NFA due to no further contacts being responded to from ex-partner 1.

February 2023

- 12.1.41 In early February ex-partner 1 reports Harry to the police again, this time for stalking. The case is NFA as ASP do not get a response from ex-partner 1 when trying to contact.
- 12.1.42 Nicole is discharged from the mental health team due to not attendance at her appointment. The next day there is a notification to the GP from SWAST 111 and psychiatric liaison unit as Nicole had taken an overdose of the prescription drug propranolol²⁰. Nicole reported having poor sleep and anxiety related to psychological issues relating to Harry. Nicole couldn't

¹⁹ <https://www.gov.uk/government/collections/fit-note>

²⁰ <https://www.nhs.uk/medicines/propranolol/>

return home as Harry was currently with the children there and she was worried he was going to make allegations against her. Nicole was referred to Open Mental Health²¹.

March 2023

- 12.1.43 Ex-partner 1 reports Harry for harassment and states he is leaving malicious communications on her business social media account. A DASH is completed and graded as high. CSC are made aware for ex-partner 1 and her children. Referrals are made for Somerset Domestic Abuse Service and MARAC.
- 12.1.44 Two weeks after this ex-partner 1 reports Harry to the police again. He is posting sexual images on social media. Arrest attempts were made in March and April, but they were negative. DA services were updated, and CSC, GP, and safeguarding in education were informed. Harry was later arrested in May when attending Nicole's home following her death. The investigation into the cases between Harry and ex-partner 1 were later closed with no further action due to insufficient evidence. A non-molestation order was issued for ex-partner 1.
- 12.1.45 In late March a parent whose child was friends with one of Nicole's children reported Nicole for giving the child alcohol. Officers attended Nicole's address and gave her 'words of advice'. No offences were identified, and the officers spoke to the parents of the children involved. Incident logged at LSU, no referral to CSC as it did not meet the threshold for making a referral.
- 12.1.46 CSC were notified of the above incident via health. Nicole was suspected of giving a 13-year-old child alcohol. The child became intoxicated and went to hospital, Nicole was reported to be intoxicated whilst caring for children and a group of their friends. The social worker (SW) spoke to Harry who stated he had taken the children at the time of the incident, and he was now seeking legal advice as he wanted them in his care because of Nicole's alcohol use. A referral was made to the area team for a child and family assessment to be completed.
- 12.1.47 Harry contacts housing to discuss his options as he progresses the custody of the children.
- 12.1.48 Four days after the incident with the children Nicole took an overdose. Nicole told SWAST that she wanted to stay at home and "*end her life*", she had sent messages to people expressing this. Eventually she agreed to go to the emergency department (ED). Nicole says she has support from her mum and a friend. SWAST note that the information they ascertain from Harry, Nicole, and Nicole's mum is all conflicting, and it is unclear as to what the truth is. Nicole's family are concerned she cannot cope with the children, and Harry is saying he will take them. SWAST complete a safeguarding referral for the children. PHN were also made aware via the hospital.

²¹ <https://openmentalhealth.org.uk/>

- 12.1.49 ASP were called by Musgrove Park Hospital - Nicole had left hospital following an overdose. She was eventually located near her home and returned to hospital. CSC were made aware.
- 12.1.50 At the end of March CSC complete a safety plan for the children. Harry is to be the main carer of all three children moving forward. Nicole is only allowed contact with the children when another adult is present, and she is not to be under the influence of alcohol or be in an emotional state in their presence.

April 2023

- 12.1.51 The SW visited Nicole at her parents' home, where her parents and a friend were present. Nicole reported daily alcohol use but stated she was attending online AA and receiving CBT for trauma and domestic abuse. Her parents confirmed a history of abuse by Harry, including verbal abuse and financial demands. Nicole agreed to return home the following week, avoid drinking around the children, and contact the police if Harry became abusive.
- 12.1.52 The SW speaks to Harry about Nicole returning home, and he agrees that the children will not be left alone with Nicole. Harry wants to remove all the children, but he is advised that this will make him intentionally homeless, and they have a home and a safety plan in place.
- 12.1.53 The same day Nicole calls the SW to say that Harry is making threats – stating he will share pictures of her empty alcohol bottles and dirty underwear. Harry told Nicole he is speaking to a solicitor and he will gain custody of the children, and she will not see them again. Nicole is told by the SW to log everything.
- 12.1.54 At the end of April, a housing officer from Homes in Somerset requested a welfare check from the police for Nicole. Officers attended Nicole's home where she disclosed, she had been physically assaulted by Harry two weeks earlier. Officers photographed extensive bruising to Nicole's body. Nicole disclosed to the police officer that she had been subject to physical and psychological abuse from Harry for many years. Nicole told the police officer she did not want to make a statement to the or pursue criminal charges. A DASH was graded as high risk, and a Blue, Red, Amber, Green (BRAG) safeguarding assessment was undertaken for the children, and graded as Red. The police attempted to contact Nicole to discuss Nicole's disclosures further, but her number was disconnected. LSU also tried to contact Nicole but could not get through. Referrals from ASP were made to education, Somerset Domestic Abuse Service, MARAC, CSC and Nicole's GP. Housing also informed CSC. Harry was arrested in May, the case was closed due to insufficient evidence.

May 2023

- 12.1.55 Somerset Domestic Abuse Service receive the only referral made for Nicole a day before she was found deceased. The DASH included the following disclosures:
- Physical abuse /CCB/ Financial abuse and control
 - Stalking/intimidation (using the child's key to enter the property)
 - Isolation from support networks
 - Controlling contact and communication (disconnecting phone, changing children's phone numbers)
 - Threats to remove/take the children
 - Encouraging self-harm/suicide
 - Nicole expressed fear
- 12.1.56 Somerset Domestic Abuse Service assessed that Nicole was on Stage 7 of Suicidal/Homicidal Ideation of the Suicide Timeline (Prof Jane Monckton-Smith). The chronology records state – *“sadly based on her final disclosures to police and housing by Nicole’s own omissions she could not see another way to stop the years of abuse”*.
- 12.1.57 The next day Nicole’s boyfriend contacted SWAST – he reported that Nicole had been vomiting the night before and he last saw her at 06:30 when he gave her a glass of milk and some water. Nicole’s boyfriend then returned to the property at 17:30 and found Nicole – he started chest compressions, and an ambulance was dispatched. Nicole had not touched the milk or water, and her phone had not been checked since 10:00. The ambulance arrived and continued with chest compressions, but they agreed to stop after speaking with the cardiac cessation team. Nicole was pronounced dead at the scene. May she rest in peace.
- 12.1.58 ASP were notified of Nicole’s sudden death by SWAST. The death was not suspicious. Harry was arrested at the scene for four offences against ex-partner 1 in April.
- 12.1.59 The postmortem revealed Nicole had died of 1a Haemorrhage from Oesophageal Varices, 1b Cirrhosis, 1c Alcohol Use Disorder. It was noted as a natural cause death, no inquest followed.
- 12.1.60 ASP notify CSC that Harry has been arrested, and that Nicole had passed away. The children were staying with relatives. Case was NFA.
- 12.1.61 Somerset Domestic Abuse Service were made aware of Nicole’s death after they followed up with the police four days after the referral.
- 12.1.62 The school nurse team received the DASH referral from the April incident 5 days after Nicole’s death.
- 12.1.63 The case was heard at MARAC 12 days after Nicole’s death and professionals were informed the children were now residing with Harry.

12.2 Overview

12.2.1 Avon and Somerset Police (ASP)

12.2.1.1 ASP believe Nicole and Harry ended their relationship in 2015 and divorced. During the timeline period there were four connected incidents recorded by ASP with Harry and Nicole, three of these related to DA. Two of the incidents were related to third party reports (see chronology data November 2020 and November 2022). Nicole denied these incidents were related to DA when spoken to by ASP. The third incident was the report from the housing officer in April 2023, a month prior to Nicole's death.

12.2.1.2 There were 3 other occasions ASP had with Nicole only, and more than 20 occasions related to Harry only. Neither were known to other police forces outside the county of Somerset.

November 2020

12.2.1.3 After the third-party report from Nicole's workplace was responded to well by officers. They attended Nicole's address and spoke to her. The records state that she expressed annoyance that her workplace had contacted the police, and she denied all reports of DA.

12.2.1.4 Despite the denial of DA occurring, the IMR author notes that a DASH was not completed, and no referral was made to LSU, both of which should have been actioned or considered after this third-party report. Although it is unlikely that this would have initiated further contact from the LSU because there were no other records of DA between Nicole and Harry at the time, the review author notes this could have provided a historic record within the LSU when further reports occurred.

November 2022

12.2.1.5 Incident 1: Police responded to the report from another parent disclosing Nicole had given their child alcohol. Although there were no offences recorded ASP followed all appropriate safeguarding practices with regards to this incident.

12.2.1.6 Incident 2: In November Nicole attempted suicide and disclosed to SWAST that she was being subjected to DA from Harry. When police questioned Nicole about this, she denied any physical abuse had occurred and said it was "*verbal only*". It was noted by ASP that by this time Harry had been referred to MARAC both as a victim and perpetrator with regards to his relationship with ex-partner 1.

12.2.1.7 The IMR author notes that there is no record at MARAC of whether safety planning for Nicole was considered in terms of Harry's history of DA with other women.

- 12.2.1.8 In addition, and given the known issues Nicole was having with substance use the IMR author also observed the following:

Although any professional is able to make a referral directly to Somerset Drug and Alcohol Service it should be noted that there is no routine referral pathway for substance abuse via police outside of established multi-agency forums such as MARAC. LSU only contact victims of crime thus no contact is made with non-crime incidents. The reasons for this relate to the complexity of information governance (and information sharing agreements) linked to the different organisations that provide these services.

April 2023

- 12.2.1.9 A report from the housing officer stating Nicole had been subjected to DA for years and had significant bruising after being recently assaulted by Harry. The report from housing stated that Nicole felt the “*only option was to commit suicide*”. Officers attended Nicole’s address and the IMR author watched the body worn video in full. The following disclosures were obtained:

Nicole reported Harry obtains keys to access the house from their son. She advised that when Harry is in the house, he is verbally abusive calling her degrading names and telling her to kill herself. Nicole reported she was subject to continuous verbal abuse and at times physical abuse from Harry, as well as controlling behaviour but had never reported it. Photos were taken of extensive bruising to Nicole’s body. Nicole told officers she did not wish to make a criminal complaint or provide a statement. It was agreed with Nicole that officers would recall discussing next steps further. A DASH was completed assessed High. Officers asked the housing officers to arrange for the locks to be changed; this took place immediately whilst officers were still at Nicole’s house. She stated Harry had changed the SIM cards in the children’s phones so that Nicole was not able to contact them. Harry had also given away the cats. Nicole declined providing a statement at the time, stating that she did not want to “*cause drama*” for the children and wanted them back. Nicole said she did not believe Harry would be found guilty.

It was also noted that Nicole did not appear to be intoxicated during the body worn video.

- 12.2.1.10 The IMR author notes that under ASP DA procedures and College of Policing guidelines²², ASP officers have a duty to take positive action on disclosures of DA. Although immediate safeguarding was actioned, by changing the locks to Nicole’s home, completing a DASH, and signposting her to Somerset Domestic Abuse Service – there was no documented consideration of immediately arresting Harry.

²² <https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches>

12.2.1.11 The IMR author notes that officers could have gathered more evidence from Nicole about her fears in relation to Harry with the potential for an evidence led prosecution being considered. Although an officer did follow up with a phone call to Nicole to discuss options around a statement, a home visit would have been more appropriate – this was especially important as Nicole had told officers she could receive but not make calls via her mobile as she had been unable to pay the bill.

12.2.1.12 The case was closed after Nicole's death due to insufficient evidence; this was partly due to the fact that the disclosures did not occur at the time of the assault and because the officer had not taken evidence of Nicole's fear, and a statement had not been obtained, the option of an evidence led prosecution was not possible.

12.2.1.13 Recommendations:

There are already improvements underway which incorporate the learning within these incidents. These are listed in section 15. In addition, the officers involved in this incident will be asked to review the Domestic Abuse video series (in particular, the evidence led prosecution video) and to reflect upon the incident and their response.

The IMR author provided very valuable analysis on the barriers Nicole may have experienced in reporting DA, and these are discussed in analysis section 13.2.

12.2.1.14 Good practice:

Communication between ASP, SWAST, and housing were noted to respond well to concerns for welfare. The review author noted there was excellent evidence of joined up working and response from ASP on disclosures by other agencies and third parties of DA.

12.2.2 NHS Somerset Integrated Care Board (ICB) – Nicole only

During the timeline period Nicole's General Medical Practice had contact with her on 20 occasions, 3 of which related to DA.

November 2020

12.2.2.1 Nicole contacted the GP after a disclosure from her workplace to ASP. Nicole contacted the GP surgery 8 days after the disclosure to explain she had fallen in the shower and had bruising and possible fractured ribs. The GP surgery prescribed pain medication.

12.2.2.2 The IMR author notes this was a telephone consultation, likely due to COVID19 restrictions in place at the time. The injuries described were consistent with a fall, but no questions were asked about DA. The IMR author also notes there were no indicators to carry out targeted questioning about DA over the phone.

March 2021

- 12.2.2.3 Nicole had several appointments relating to her increased drinking in which she disclosed Harry was threatening to take the children away. The IMR author notes the good practice in relation to inquiring and safeguarding the children, and a robust response to substance use and mental health issues. Although there was signposting to Somerset Domestic Abuse Service there was no targeted questioning of DA, and this was a missed opportunity.

April 2021

- 12.2.2.4 In April Nicole's mum called the GP surgery concerned for Nicole's mental health (MH). Nicole was sitting in bed all day and her mum had stopped her from taking an overdose. Mum reported being worried that Nicole was hiding her feelings. A referral was made to the Home Treatment Team (HTT) for mental health support.
- 12.2.2.5 The assessment by HTT detailed disclosures from Nicole about the abusive behaviour of Harry and that he was using the children to control her. Nicole was fearful of Harry's father describing him as a well-known drug dealer in the area who could "*kill her at any time*" or "*smash up her property*". HTT confirmed Nicole had accepted the contact details for Somerset Domestic Abuse Service, but she declined further support for her MH.
- 12.2.2.6 The IMR author noted that there was no coding of DA attributed to Nicole's records, which can prompt other primary care workers to ongoing DA. The IMR author offers recommendations in response to this.
- 12.2.2.7 The review author also noted a pattern of signposting to Somerset Drug and Alcohol Service rather than referring Nicole directly. In addition, had domestic abuse targeted clinical inquiry been carried out more routinely for Nicole she could have been signposted to Somerset Domestic Abuse Service. This is analysed further in section 13.2.

June and November 2021

- 12.2.2.8 In June and November 2021 Nicole sought support from her GP in relation to her drinking and the fact she had lost her job. Due to the fact no coding had been applied on previous disclosure of DA, the first appointment in June did not result in any further targeted inquiry.
- 12.2.2.9 At the November appointment Nicole explained ex-partner 1 had thrown her children out of the home at 4am, and CSC were involved. There was no targeted inquiry into domestic abuse at this appointment either and the IMR author offers recommendations for GPs for phone consultations and targeted inquiry of DA.

November 2022

- 12.2.2.10 Nicole was taken to hospital after an overdose in November 2022. Nicole had described the DA from Harry to SWAST and this information was shared with the GP. DA Coding was not applied to the records again after this incident.

January 2023

12.2.2.11 The practice was in regular contact with Nicole for her ongoing health issues relating to alcoholic liver disease. In January there was a thorough assessment undertaken, where issues relating to the recent suicide attempt and financial issues were discussed. No inquiry was made about DA at this appointment, and this may have been exacerbated by the lack of coding, this was especially important as the appointment was not undertaken with Nicole's regular GP who knew her well.

12.2.2.12 Latterly Nicole did follow up with her usual GP at a face-to-face appointment. Nicole stated she felt Harry's abuse of her had caused her to attempt suicide, and she regretted it. Nicole had no current suicidal ideation and her drinking had decreased. The IMR author noted there was no signposting to DA services after these disclosures and offers recommendations in relation to this.

February 2023

12.2.2.13 After another attempted suicide by Nicole SWAST informed the GP surgery of the incident. The report received included references to depression and '*psychological difficulties*' with Harry. Nicole was referred to open mental health services, but the incident and subsequent disclosures were not explored further in relation to domestic abuse. Recommendations are offered by the IMR author.

April 2023

12.2.2.14 The housing officer referral to the police where Nicole had significant bruising and disclosed ongoing physical abuse and CCB from Harry resulted in a notification to the GP surgery. The information sharing on this incident was noted to be very good practice by the review author, but the IMR author notes that this information sharing process will cease in April 2025 due to a lack of funding for administrative support. The IMR author offers a recommendation in relation to these cuts to services.

12.2.2.15 Good practice:

There was good practice in referrals to HTT from Nicole's GP - HTT responded swiftly to the referral and followed up with the GP. The first January 2023 appointment was noted to be very detailed and there was good practice in terms of encouraging Nicole to follow up with her usual GP.

There was good practice during COVID19 in relation to support offered to Nicole, and evidence of good support offered for substance use and mental health services. Information sharing between agencies and the practice were also noted to be good.

12.2.2.16 Recommendations:

The IMR author offers 7 recommendations for primary care and GP practices across Somerset, and these are reflected in the section 16.

12.2.3 Somerset Public Health Nursing (PHN)

Although PHN had no direct contact with Nicole, Harry or any of their three children they did receive notifications from the following agencies:

- SWAST – November 2022 and March 2023 – notification of attempted suicide by Nicole
- Yeovil District Hospital – March 2023 - notification of concerns about lack of parental supervision after Nicole had given alcohol to children at a sleepover
- DASH received by school nurse – May 2023 – this was completed in April after Nicole's disclosure to the housing officer of physical and psychological abuse. The DASH was completed seven days before Nicole died and received by PHN five days after Nicole's death (12 days after disclosure).

12.2.3.1 The IMR author notes the information received from SWAST in November 2022 detailed Nicole's suicide attempt and how she was struggling with her mental health, with clear references to Harry's emotional abuse and threats to take the children. The notification was also sent to CSC, Somerset NHS Foundation Trust safeguarding team, ASP, and the GP. PHN received the notification due to concerns about the children's well-being, care and safety. At that stage the children were not open to the school nurse, so they had no direct contact, but it was stated in the PHN records that schools would be contacted by the School Nurse to make them aware of this notification, there are no records evidencing this took place. The IMR author notes this would usually be a standard follow-up procedure after concerns regarding DA and mental health issues. PHN did not receive any information about this incident from other agencies, and the DASH completed by SWAST was not shared with the school nurse either. On the latter point the IMR author notes school nurses don't routinely receive DASH forms in all circumstances.

After Nicole's second suicide attempt PHN received another notification but there was no reference to DA contained within the referral, and the children were said to be living with Harry, so no further involvement was actioned by PHN.

12.2.3.2 The IMR author notes the notifications sent were primarily from SWAST and they highlighted the significant mental health concerns for Nicole, and the impact on her children. The IMR author raises the following importance of information sharing between agencies:

12.2.3.3 This was an example of a large range of services receiving this information but no liaison between services in relation to either her mental health or the factors impacting her mental health which were probably caused by her being a victim of domestic abuse. Liaison between services would help to understand roles with the system to support both the main subject of the notification and family members.

12.2.3.4 Good Practice:

The review author noted the good practice in information sharing between agencies after Nicole had attempted suicide. The records shared detail the issues she is dealing with, including the DA she is being subjected to by Harry.

12.2.3.5 Recommendations:

The IMR author offers recommendations in relation to improved multi-agency liaison after notifications are received by SWAST, these are reflected in section 16. The IMR author and the panel analysed the importance of information sharing in relation to barriers for victims of DA in section 13.2.

12.2.4 Somerset NHS Foundation Trust (SFT)

During the timeline period SFT had contact with Nicole on 14 occasions, 4 of which related to DA.

April 2021

12.2.4.1 After Nicole's mum contacted the GP with concerns for Nicole's mental health, Nicole agreed to a mental health assessment, and the Community Mental Health Team (CMHT) visited her at home the next day:

Nicole explained she came out of a 17-year controlling and abusive relationship 5 years ago but that she still *'lives in fear of her life'*. She said the past abuse affects the way she lives her life now. She has recently been drinking heavily as a way to cope.

12.2.4.2 The IMR author notes DA was explored within the assessment but offers analysis on professionals remaining professionally curious around the co-occurring presentation of mental health, and substance use being a factor for victims of DA. The IMR author suggests Nicole could have been assisted to contact DA services during the home visit.

November 2022

12.2.4.3 After Nicole attempted suicide, she disclosed the abuse from Harry to professionals at the Emergency Department (ED). ED recorded that Nicole was already seeking help from AA, and she was referred to Open Mental Health Services, and given the number for HTT. Nicole was also assisted with distraction techniques. The IMR author notes that there was a lack of professional curiosity from the ED in regard to DA and Nicole was not signposted to DA services.

12.2.4.4 Overall, the IMR author observed ED had seen Nicole on four occasions and two of these were after suicide attempts, she also attended Musgrove Park Hospital (a local acute hospital) for physical health problems relating to her excessive alcohol use. The IMR author offered excellent analysis on the need for professional curiosity to explore the impact on a victim's mental health and use of alcohol, particularly in relation to coercive and controlling behaviour and the use of children by perpetrators to exert power. Additionally, the IMR author notes a degree of potential unconscious bias and offers analysis and recommendations in relation to trauma informed care, these points will be discussed further in section 13.2.

12.2.4.5 Good practice:

The review author noted the swift response from CMHT when visiting Nicole at home the day after her mum called the GP with concerns.

12.2.4.6 Recommendations:

The IMR analysis resulted in three recommendations for SFT, and these are reflected in section 16.

12.2.5 South Western Ambulance Service NHS Foundation Trust (SWAST)

During the timeline period SWAST had contact with Harry on 1 occasion and Nicole on 3 occasions.

July 2022

12.2.5.1 In July 2022 Harry contacted 111 after taking an overdose. An ambulance was dispatched, and he was taken to hospital. Harry stated he had been struggling to cope. The IMR author notes there was no professional curiosity around why Harry was struggling to cope but confirms this incident pre-dated professional curiosity training for staff.

November 2022

12.2.5.2 Nicole called 999 after an attempted suicide. En-route to hospital Nicole disclosed a history of sexual abuse and current DA from Harry. The IMR

author notes all information, including the DASH was completed and shared in a timely fashion with other agencies.

March 2023

- 12.2.5.3 A family member called 999 after Nicole attempted suicide. The chronology evidences this was 4 days after Nicole had given children alcohol at her address. SWAST records note Nicole had text Harry's brother at 09:30 after the children went to school, she said she wanted to kill herself as the children would be better off without her – she also said she didn't want her children at her funeral. Harry's brother notified, Harry, his sister, and Nicole's mum.
- 12.2.5.4 On arrival the ambulance crew were met by Harry's sister and Nicole's mum, who stated she did not want an ambulance and could become aggressive. However, Nicole engaged with the ambulance crew. The IMR author notes there were conflicting versions of events from all parties involved, and this was a complex situation. Nicole's family did state they were concerned Nicole could not look after the children until she got support for her mental health.

Detailed information was shared with CSC, PHN, and the GP.

12.2.5.5 Good Practice:

The review author noted the good practice in information sharing and completion of DASH assessments from SWAST throughout the chronology data. Nicole clearly felt able to disclose the abuse she was being subjected to when speaking with ambulance crew, and they should be commended for their trauma informed care and record keeping.

12.2.5.6 Recommendations:

SWAST note the lack of professional curiosity in relation to the incident with Harry but confirm this training has now taken place. They offer no other single agency recommendations.

12.2.6 Somerset Children's Social Care (CSC)

During the timeline period CSC had contact with regards to Nicole and Harry's children 6 times. The IMR author noted only one contact was in relation to Nicole disclosing DA from Harry in November 2022. At the time of Nicole's death, the children were open to CSC and were residing with Harry, a Children and Family (C&F) assessment was being completed in relation to Nicole's alcohol use and mental health issues. Historically Nicole disclosed extensive CCB over 17 years to the CMHT crisis team in April 2021 and it is noted that this was not shared with CSC at the time

October 2021

- 12.2.6.1 CSC received a notification from ASP in relation to Harry being a victim of DA from ex-partner 1. The children were present at an incident where it had been alleged ex-partner 1 had hit Harry with a frying pan and tried to smother him with a pillow. Harry had contacted Nicole to pick the children up and he was open with CSC about the incident stating he had ended the relationship with ex-partner 1.
- 12.2.6.2 Nicole was spoken to and reported that one of the children was restless and sleeping with her, the oldest child had tried to intervene in the incident and prevent ex-partner 1 from attacking Harry, and their third child was tired. Nicole told CSC that Harry was a good dad and not violent. Education was informed to continue further support for the children. The file was NFA due to both parents acting protectively towards the children, and Harry stating the relationship had ended.

September 2022

- 12.2.6.3 Another notification was received from ASP where Harry had allegedly been the victim of DA from ex-partner 1 and her associate. Harry had his windows and car windscreen smashed. Ex-partner 1 alleged Harry grabbed her and slapped her round the face. The children were not present at this incident. This police report was shared with CSC 20 days after the incident after a request from MARAC.
- 12.2.6.4 CSC spoke to Nicole who disclosed Harry had agreed five months prior to ensuring the children had no contact with him whilst ex-partner 1 was present. A safety plan was in place. Harry corroborated this information in a separate discussion.
- 12.2.6.5 CSC had no information about what ASP were doing in relation to the counter-allegation made against Harry by ex-partner 1, and they did not explore this allegation with Harry directly or follow up with the police. The review author noted ASP were unable to take this allegation further due to unsuccessful contact attempts with ex-partner 1.

November 2022

- 12.2.6.6 A notification was received from SWAST regarding Nicole taking an overdose and drinking a bottle of wine, with the intent to end her life. A social worker (SW) spoke to Nicole in detail, and she shared that during her relationship with Harry he had constantly been horrible to her telling her she was *"fat and ugly."* Nicole told the SW that ASP had been to see her about the emotional abuse from Harry.
- 12.2.6.7 Nicole stated that the abuse was not ongoing, and that she felt terrible about taking the overdose, but confirmed the children were at school at the time. She stated she was taking anti-depressants and had been referred to counselling. Nicole explained she effectively managed being a single parent and Harry saw the children, but he paid no maintenance. Harry had promised Nicole he would see the children twice a week and apologised for not being there for the children more.

- 12.2.6.8 Harry was spoken to, and he spoke positively about Nicole as a parent and stated he had no concerns about the children in Nicole's care.
- 12.2.6.9 CSC were not informed of any actions ASP were taking in regard to the emotional abuse - we know from the ASP chronology data and IMR that a perceived DASH was graded as standard, and no current offences or emotional abuse were disclosed, but the data regarding Harry as a victim of DA and being referred to MARAC was not triangulated.
- 12.2.6.10 The SW did not speak to Harry about the allegations of DA from Nicole, as he was not aware, so it was not deemed necessary. The SW did not speak directly to the school about the children and therefore did not conduct an up-to-date penned picture of how the children were presenting at school.

January 2023

- 12.2.6.11 An ASP report was shared with CSC regarding an incident of DA between Harry and ex-partner 1. Ex-partner 1 was arrested for assaulting Harry and at interview she told the police that Harry assaulted her by pushing her to the floor several times and calling her a *"fat slag, and a scabby bitch"*. The children were not present at this incident.
- 12.2.6.12 Harry spoke to the SW and said he wanted to forget about the incident and move on with his life. He said the children lived with Nicole and he saw them twice a week. The SW noted that this was the third incident of DA reported between him and ex-partner 1.
- 12.2.6.13 Initially Nicole was not responding to calls, so the SW wrote a letter to her, and she called in to CSC – she confirmed a safety plan was in place and the schools were aware, with one of the children being offered further support. Following Nicole and one of the children's schools being spoken by the SW the case was NFA.
- 12.2.6.14 The SW did not speak to Harry about the counter allegations of DA made by ex-partner 1.

March 2023

- 12.2.6.15 An Early Help Assessment was completed by health and shared with CSC that Nicole has become intoxicated whilst she had her own children and several of their friends in her care. One of the children became intoxicated requiring medical intervention and treatment. Harry had collected the children, and a C&F assessment was progressed.
- 12.2.6.16 When Harry was spoken to, he stated Nicole had *"always been a big drinker"* and he was seeking legal advice about getting custody of the children. Attempts were made to contact Nicole, but she did not respond.
- 12.2.6.17 Four days later Nicole took an overdose and was taken to hospital. SWAST shared this incident with CSC. The children were noted to be at school at the time. The SW completed a home visit with Harry and instigated an immediate safety plan. It was agreed that Harry would remain in Nicole's home with the children, and she would go and stay with her parents – Nicole was not allowed to be on her own with the children. It was planned that the

SW would go and see the children at school the next day but there were no follow up notes to indicate whether this happened.

April 2023

12.2.6.18 A SW visited Nicole at her parents' address. Nicole disclosed that Harry was preventing her from seeing the children. Nicole disclosed her drinking was poor and she was consuming two bottles of wine a day – she was struggling with anxiety and missing the children. It was recorded on the notes that Nicole shared with the SW there was a lot of emotional abuse from Harry, and Nicole's parents told the SW that this had been going on for years. Harry would let himself into Nicole's house, demand money from her and shout at her. The SW advised Nicole to ask Harry to leave and call the police if this happened. A plan was put in place for Nicole to return home and when the children came home from school Nicole's mum would be there to supervise her and the children. Nicole agreed not to drink around the children and wait until they were in bed.

12.2.6.19 Harry is subsequently spoken to, and he agreed the children would not be left unsupervised with Nicole. Harry said he wanted to remove the children, but he was advised if he did, they would become intentionally homeless, and the accommodation they have at Nicole's home is appropriate with safety planning in place.

12.2.6.20 In mid-April Nicole called the SW and told them Harry had been threatening to post photos of her dirty underwear and empty alcohol bottles – he told her he was going to get custody of the children, and he was seeking legal advice. The SW told Nicole to log everything with the police. Harry was not spoken to by the SW about this disclosure.

12.2.6.21 At the end of April, the Homes in Somerset housing officer called CSC informing them that Nicole was not answering the door. The housing officer was concerned that Harry had taken the children and Nicole was feeling suicidal. The housing officer informed CSC that they had contacted ASP. We know from the ASP and Housing data that this preceded a disclosure of physical assault from Harry and pictures were taken of extensive bruising to Nicole. ASP called the CSC Emergency Duty Team (EDT) at the time of the incident and EDT requested a voicemail was left. ASP also shared the incident directly with CSC one day prior to Nicole's death.

12.2.6.22 There are no records of any actions CSC took after the call from housing, or any follow up they conducted. CSC became aware of the full information after Nicole's death.

12.2.6.23 Social workers reflections

The IMR author interviewed the social worker for the IMR. The SW reflected this was a fast-moving case and she spoke to the children directly twice. The focus remained on Nicole's drinking and mental health and the impact this had on the children. They were not asked about DA and Harry was never spoken to about the allegations of abuse either.

12.2.6.24 Good practice:

It is positive on the occasions where Harry was the alleged victim of DA from ex-partner 1 that both parents were spoken to. The IMR author interviewing the social worker was a very useful process for the panel and provided contextual information for the review analysis and learning for CSC.

12.2.6.25 Recommendations:

No referrals were made to Somerset Domestic Abuse Service for Nicole and the review author noted that no DASH was completed with her. The IMR author provided useful analysis for the panel regarding the lack of exploration of DA disclosures provided to CSC by Nicole and other agencies, this will be further explored in section 13.3. Additionally, the IMR author notes the limited consideration for Nicole after it was agreed she would return to the property with Harry staying there with the children. The focus of CSCs involvement remained on Nicole's inability to parent safely.

The IMR author notes Harry utilised his parental responsibility rights and removed the children from Nicole's care. Further the C&F assessment was still ongoing at the point of Nicole's death and thus sadly there was no further opportunity to explore the DA disclosed.

The IMR author offers four single agency recommendations, and these are reflected in section 16 of the review.

12.2.7 Housing Options & Homelessness, Somerset Council (formerly Sedgemoor District Council):

The Housing Options Team had 37 interactions with Harry during the timeline period. The majority of these contacts were via phone or email. The IMR author noted 34 of the interactions were appropriately recorded and offers recommendations for 3 interactions where poor record keeping was noted.

Harry

March 2022

12.2.7.1 Harry disclosed he was a victim of abuse from ex-partner 1 and on one occasion in March 2022 MARAC information was shared with Housing. He was placed in temporary accommodation after this and continued to be supported with his homelessness applications. Harry was placed in private rental accommodation at the end of March 2022.

12.2.7.2 This tenancy only lasted five months and Harry surrendered his tenancy and moved in with his father, citing declining mental health issues.

March 2023

12.2.7.3 Housing was contacted by ASP and notified them that Harry was homeless. ASP noted that Harry needed advice on how to secure accommodation for him and the three children following safeguarding issues relating to Nicole regarding the incident when she gave alcohol to children (including their daughter) who were on a sleepover. It was noted that ASP and CSC were

investigating this incident. Harry expressed a desire to get custody of all three children and disclosed Nicole's overdose the year before. Harry declined to pursue a housing application at this stage.

- 12.2.7.4 Later in March after Nicole attempted suicide again Harry disclosed this to housing, and it was noted that social care was involved. A new homelessness application was granted in April 2023.
- 12.2.7.5 The IMR author notes that Harry was provided with appropriate and thorough advice regarding his housing options. The IMR author does note that Harry contacted the switch board on several occasions but there were no notes of what these conversations contained.

Nicole

- 12.2.7.6 There was no data available for Nicole on Somerset District Council records within the timeline. However, the panel noted the information shared by a housing officer to the police detailing concerns for welfare in April 2023 which precipitated further safeguarding referrals.
- 12.2.7.7 This information was held under the Housing Association, Homes in Somerset, that managed Nicole's property, and they provided the panel with a detailed analysis of their involvement dating back to 2011. Initially the tenancy was held jointly between Nicole and Harry, but he was removed from the tenancy in 2015 after they split. Prior to 2021 the majority of contacts between Nicole and her housing officer were around minor repairs and damp at the property.

August 2021

- 12.2.7.8 Nicole contacted the income officer, and she was very distressed. She explained she was suicidal and was struggling with finances. Advice was given to Nicole on accessing Universal Credit and a food voucher was offered which she declined. Latterly in December 2021 and in early January 2022 Nicole accepted food vouchers from her housing officer and she reported being supported by Citizens Advice Bureau to help her manage her debts.

November 2022 to January 2023

- 12.2.7.9 Arrears on Nicole's property continued to be a problem and she was in regular contact with her housing provider around this. Support was provided to her on every occasion, and she was trying hard to manage the debt, but informed housing in January 2023 that Harry had stopped paying maintenance.

April 2023

- 12.2.7.10 The Income Officer visited Nicole, and she was covered in bruises. Nicole disclosed that her phone had been cut off, and Harry had come into her house taken her property, removed the children and taken her cats. Nicole disclosed she was suicidal, and the bruises were as a result of Harry attacking her, but she was too scared to report to the police because Harry's family were known drug dealers.

12.2.7.11 The housing officer went out to visit Nicole the next day and got no answer, so they made immediate referrals to CSC and the police as a concern for welfare. This was 7 days before Nicole's death.

12.2.7.12 Good Practice:

Harry was supported well by housing during contacts and given appropriate advice. The interactions with Nicole and her housing provider were noted as best practice and have resulted in recommendations which are detailed below and in section 15.

12.2.7.13 Recommendations:

The IMR author offers recommendations for housing staff on the importance of thorough notetaking. In addition, there is a recommendation on the timeliness of housing applications. These are reflected in section 16.

The review author and panel would like to commend the housing officer who shared the information with agencies on the incident in April 2023. The pro-active information sharing was exemplary and should be used as an example of best practice for other housing staff. The panel offer a recommendation regarding this in section 15 of the review.

13 Analysis

The benefit of hindsight enables the Chair and the panel to assess where different decisions or actions could have been a catalyst for support and or intervention for Nicole. This analysis is based on information provided in the IMRs and, perhaps more importantly, Nicole's family/friends provided a focus for the panel to understand a more holistic perspective of the situation. The panel additionally noted the high calibre of the IMRs from all agencies and were grateful for the input from authors as it enabled robust analysis.

13.1 Coercive Controlling Behaviour

Relevant TOR points:

- *Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.*
- *To discover if all relevant civil or criminal interventions were considered and/or used.*

Coercive control legislation came into effect in the UK on the 29th of December 2015. To understand domestic abuse holistically we must understand that coercive and controlling behaviour acts as the backdrop to physical and or sexual violence²³.

²³ <https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf>

The cross-Government definition of domestic violence and abuse outlines controlling, or coercive behaviour as follows:

- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
- Controlling or coercive behaviour does not only happen in the home; the victim can be monitored by phone or social media from a distance and can be made to fear violence on at least two occasions or adapt their everyday behaviour as a result of serious alarm or distress.²⁴

We know Harry was coercively controlling because Nicole told agencies he was. When Nicole was referred to the mental health crisis team in April 2021, she disclosed she had been subjected to physical and emotional abuse for 17 years and although she split up from Harry 5 years prior, she stated she *“lives in fear for her life”*.

After Nicole attempted suicide in November 2022, she made further disclosures of CCB to SWAST and ED. Appropriate referrals were made to CSC and ASP regarding these disclosures and Nicole told the social worker that Harry would call her *“fat and ugly”* and he paid no maintenance. It is of note ex-girlfriend 1 told the police in January 2023 that Harry had pushed her to the floor and called her a *“fat slag, and a scabby bitch”* – the similar degrading language appears to be a pattern from Harry in his abusive behaviour towards women.

There were other signs and signals of CCB that professionals were made aware of. In April 2023 Nicole told the social worker that Harry was preventing her seeing the children, and that she had been abused for years; Nicole’s parents corroborated this account with the social worker. A day after this disclosure, just before her death, Nicole also disclosed to the social worker that Harry had been threatening to post photos of her empty alcohol bottles and her dirty underwear onto social media. Nicole described how Harry had a key to the property, would let himself in and shout at her, demanding money, he would also cut off her phone and prevent her from speaking to the children. Harry would also tell Nicole to kill herself. The threats Harry made towards Nicole were shameful and degrading and it must have taken a lot of courage for Nicole to disclose them to the social worker – she would have undoubtedly been frightened of

²⁴ Controlling or Coercive behaviour in an intimate or family relationship – Statutory Guidance Framework – Home Office December 2015 p. 3-4
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

repercussions, both in terms of what Harry might do next and because social care had removed the children from her care placing them with Harry as the primary carer.

After the disclosures the police made contact, whereby Nicole denied there was any physical abuse and said it was verbal abuse only and that she would speak to Harry about the children through a third party. In addition, she gave conflicting information to the police and the GP in November 2020 after her employer made a report about physical violence from Harry, telling the police she fell in the bath, and then telling the GP she fell in the shower, this may seem a minor detail but it is an inconsistency that is worth noting. In addition, Nicole was frustrated when her employer informed the police but we know when victims are in fear they may present as angry that third parties are “interfering” and in their distress to divert attention from the perpetrator they may not always be consistent in explaining away injuries. Nicole told both CSC and ASP that the abuse was not ongoing. Research²⁵ details the ways in which female victims will manage the stress and trauma using cognitive strategies which include denying and or minimising the abuse – this is both a trauma response and a way to keep themselves safe practically and emotionally:

“Coping is a multidimensional process, and humans are believed to implement a range of strategies to adapt and reduce stress arising from traumatic situations...Psychological coping strategies, such as minimizing (the process of omitting some information about the abuse when disclosing it), appear to have attracted less research; but one study showed that just over a third of women sampled demonstrated minimization, which was related to abuse severity...Other cognitive strategies may include denying abuse severity, trying to ignore it, using humour and trying to be optimistic.”

The compliant behaviour of perpetrators is also a common tactic that professionals need to be alert to. Harry simultaneously praised Nicole’s parenting when asked by social workers and systematically destroyed her self-esteem behind closed doors. She was not only frightened of him, but also of his family.

Perpetrators systematically destroy a victim’s self-esteem through their use of CCB, and it leaves victims feeling exhausted and lonely. It is apparent throughout the data that Harry was never challenged about his abuse towards Nicole, despite him being a known perpetrator of three women. The onus for professionals was directed towards Nicole’s mental health and substance use, and although she repeatedly told professionals she had been subjected to abuse for a long time, there was a lack of pro-active specialist support offered to Nicole in response to these disclosures – in addition, there was a limited professional curiosity surrounding the reasons why Nicole was drinking heavily and her mental health was suffering. Research reveals²⁶ that women are two times more likely to use alcohol as a coping mechanism after being subjected to long-term domestic abuse, and perpetrators use this to their advantage.

²⁵ https://uhra.herts.ac.uk/id/eprint/5835/1/Final_accepted_version_4_Nov_2016.pdf

²⁶ <https://www.ias.org.uk/report/domestic-abuse-sexual-assault-and-child-abuse/#:~:text=There%20is%20evidence%20that%20victims,their%20violent%20partner%20%5B8%5D.>

The subtlety of coercive behaviours exerted by perpetrators form a picture of the power they can hold over victims even when things are seemingly “good” or “normalised” from an outside perspective.

Professionals are becoming much more adept at acknowledging the signs of CCB and because of other DHRs multi-agency responses in Somerset have provided a much-needed focus on this area of knowledge for professionals. The intersecting needs of victims with multiple and complex needs does need more focus nationally and the reality is there is a lack of specialist support for victims who have co-occurring issues. These issues often result in barriers in reporting and thus barriers for professionals to offer support.

13.2 Barriers to Reporting

Relevant TOR Points:

- *Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.*
- *Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.*
- *Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.*
- *Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.*

Nicole did not contact the police herself, but we can see that ASP positively proactively responded to third party reports of DA, and they spoke to Nicole on each occasion dating back to November 2020. The data revealed a pattern of Nicole did not feeling able to disclose the abuse was occurring, apart from on the last disclosure when she told police about the abuse – and even then Nicole felt unable to make a statement to police, citing her reasoning that she did not want to disrupt the children and wanted to ensure she had access to them.

As described above many victims minimise or deny the abuse they are being subjected to, this often results in victims not pursuing options made available to them – which in turn presents as a yoyo effect of victims appearing to dip in and out of the system. The Domestic Abuse Commissioner has highlighted only 6% of reported DA

incidents result in conviction, and she further notes the reasons why 80% of victims do not support criminal justice interventions²⁷, acknowledging that the system was never designed to respond to the epidemic of DA that exists in our society. In offering recommendations, the Commissioner focuses on what happens at the start of the disclosure journey for victims, arguing that it is early intervention and prevention that can enable victims to get support.

It is undeniable that professionals responded with pro-active interventions regarding Nicole's alcohol and mental health issues, however, the same cannot be said about the DA she was being subjected to. Despite professionals being made aware of the DA, either by third parties or by Nicole herself the onus was placed on her to contact domestic abuse agencies for support – this was also true in part of the signposting rather than referrals to Somerset Drug and Alcohol Service. The observation from the expert in substance use noted

Quite often, offering to do a referral rather than signpost can encourage someone to accept help. It can be a huge step for someone to pick up the phone and refer themselves.

Nicole was offered referrals to Somerset Drug and Alcohol Service but declined these as she had CBT counselling in place, and she also disclosed she was accessing AA. Although we have no way of verifying this information, there is nothing to suggest that Nicole was misleading professionals, but it may be she was reluctant to access support offered by agencies because she had learnt how to cope alone – this would be necessary to manage the abuse she was being subjected to by Harry, and to keep agencies at arm's length – which is not uncommon when victims with children have multiple and complex needs, as they fear losing them. When Nicole attempted suicide in November 2022, there is nothing in the records to evidence her being spoken to by professionals about her alcohol use and the impact this was having on both her and the children – the expert panel member for substance use services noted that at that point Nicole and the children could have been offered support via Hidden Harm Somerset²⁸.

Throughout the data Nicole also disclosed she had been subjected to sexual abuse and rape as a child; this early experience of men's violence would have dictated her trauma responses in later years when she was subjected to abuse as an adult. There is nothing in the data to suggest that these disclosures were explored with Nicole in any detail – which could have provided a much-needed context for Nicole's apparent unwillingness to trust agencies and her excessive use of alcohol and declining mental health issues.

Agencies are often not set up to respond well to victims with multiple and complex needs, and victims themselves report²⁹ the abuse can sometimes be the “*least of their worries*” – and they are having to deal with entrenched mental ill health and substance

²⁷ <https://www.gov.uk/government/publications/transforming-the-criminal-justice-response-to-domestic-abuse/shifting-the-scales-transforming-the-criminal-justice-response-to-domestic-abuse-accessible>

²⁸ <https://www.somerset.gov.uk/children-families-and-education/drug-and-alcohol-services-for-young-people/>

²⁹ <https://www.vonne.org.uk/sites/default/files/files/resources/TooComplexEvaluation-Nov2018.pdf>

issues alongside financial problems – this often deems victims too complex to deal with and perhaps subconsciously professionals focus in on the presenting issue which is understandable given the lack of resources for victims. The review author observed the numerous DHRs she had completed where multiple and complex needs were present – and yet still resources are inadequate to respond to victims with these issues. The prevalence of the barriers to support are well known, with national research evidencing:

“There are higher rates of domestic abuse amongst people who have mental health problems compared to those who don’t. Research supports the existence of a bidirectional relationship; domestic abuse can lead to mental health difficulties, and having mental ill health can render people more vulnerable to domestic abuse”³⁰.

“Living with domestic abuse can be extremely frightening, distressing or exhausting. This can cause some people to drink alcohol to try to cope with the physical and mental health impacts of domestic abuse. Research shows that women who experience extensive physical and sexual violence are more than twice as likely to have a problem with alcohol than those with little experience of violence and abuse, additionally, alcohol abuse can increase an individual’s vulnerability to abuse”³¹.

It is important to note that Nicole only became known to agencies in the latter years of her life. From this we can deduce Nicole held things together extremely well even though Harry had been abusive towards her for nearly half of her life. There was a rapid decline in Nicole’s life when agencies became involved after she gave children alcohol at her home – it was just over one month from that report to her death and in that time, she lost her children to Harry and was desperately trying to manage her alcohol intake to keep the children safe – again the onus was placed on her by CSC to report any further abuse to the police. We know Nicole had already told police she didn’t want to make a statement because she feared not having contact with the children, but there is nothing in the data to suggest that CSC were aware of this information.

In this sense although information sharing was generally very good between professionals, the liaison of contextual information was inconsistent, and this can act as a barrier for victims to get support, particularly when they have multiple and complex needs. The information available about Harry was that he was known as both a victim and a perpetrator of DA, Nicole was even questioned about this and asked to provide assurances around the children about Harry’s behaviour towards ex-partner 1. In April 2023 Nicole was referred to MARAC with Harry listed as the perpetrator, however, it is surprising that she was not contacted prior to this as Harry had been listed on 7 previous MARACs and the panel queried why Nicole hadn’t been taken into

³⁰ [Safe-and-well-Mental-health-and-domestic-abuse-spotlight-report.pdf](#)

³¹ [Alcohol and domestic abuse | Alcohol Change UK](#)

consideration in terms of safety planning or offers of support as part of previous MARAC action plans.

Nicole was disclosing for long enough that agencies did have opportunities over the years to be more professionally curious and targeted in terms of DA support with the triangulated data of Harry perpetrating against ex-partner 1, the third-party reports about Nicole being a victim, and the disclosures Nicole was making herself. But by the time agencies were fully involved with the family Nicole was in an impossible position and the only referral made for her to DA support arrived with Somerset Domestic Abuse Service after her death.

Professional curiosity is not just one part of solution, when victims don't access support or pursue interventions professionals need to apply trauma informed practice and think less about autonomy of choice, and much more about why victims aren't responding in the ways we think they should:

- What trauma are they, or have they been experiencing
- Who are they protecting
- What has worked up until now to keep themselves safe (positive and negative coping mechanisms)
- What has their previous experience been with agencies
- Is the presenting issue the only one – how many other agencies are involved
- What are our expectations of them and are they reasonable and safe
- What are they disclosing to agencies collectively
- Who has spoken to or challenged the alleged perpetrator

Somerset have made significant improvements in relation to trauma informed practice³² and professional curiosity since Nicole's death, and the panel will suggest Nicole's story is shared with partners to highlight the importance of understanding the systemic barriers some victims face when accessing support for DA.

13.3 Children as Victims of Domestic Abuse

Relevant TOR Point: Determine if there were any barriers the victim faced in both reporting domestic abuse and accessing services. This should also be explored:

- *In regard to children and any potential impact this had ensuring the safeguarding of any children during the review.*

It is regrettable the panel were not able to fully explore the children's voices for the review process. However, given the safeguarding concerns assessed the panel hope the below analysis reflects some of their experiences.

We know that Harry exerted abuse and control over Nicole and ex-partner 1. Although the panel acknowledge that the children were not present in the household when Harry was abusive towards ex-partner 1, this does not mean they were not aware of the aftermath of the abuse. In addition, given Nicole disclosed years of abuse from Harry,

³² <https://traumainformedsomerset.org/>

the definition of them as victims correlates to section 3 of the DA Act 2021³³ and thus we can confidently state they were victims of DA in their own right. The expert panel member for substance use services observed the children could have been considered for support under the Family Safeguarding Team³⁴ earlier on in their contact with children's social care, and this could have provided some wrap around support for the family.

The plan for Nicole to return home with Harry in her house after she had attempted suicide and had a period of time at her parents, did not consider her as a victim of DA. Just prior to her returning to the property she disclosed to the social worker that she had been subjected to DA by Harry for years, and yet she was also expected to manage being in the same house as him with the children. In addition to this because the children were not asked about DA, we have no way of knowing how this arrangement would have impacted them. Ultimately Harry was not happy with the arrangement for Nicole to return to her own home to be with the children, so he removed them. Although through the social work records, we know the children found it hard to be with their mum whilst she was so unwell, having Harry remove them from the family home and away from Nicole must have brought up complex emotions for the children - and it must have been particularly be difficult for Nicole – the last days of her life must have been very distressing without her children.

The children were asked about Nicole's mental health and alcohol issues, although it was pointed out by the substance use panel expert that the children could have been referred to Hidden Harm support via Somerset Drug and Alcohol Service under the joint working protocol, and this could have ensured support for them directly on the impact of Nicole's drinking.

However, the children were never asked about the DA that Nicole disclosed and neither did CSC challenge Harry on his behaviours. As with previous analysis the focus for the children's safety was on Nicole's drinking, and whilst the panel acknowledge this was a fast-moving case that needed immediate intervention, there were opportunities to explore the DA with the children more directly, and because they weren't asked, we are missing their voices as victims of DA within the review data.

The Domestic Abuse Commissioner published research³⁵ in 2025 cataloguing the voices and experiences of child victims of DA. It is worth acknowledging that the scale of the problem is unknown because data collection is lacking in official statistics and the numbers of children affected by domestic abuse are hampered by underreporting.

Nonetheless we know that the impact of DA on children is significant and exposure to DA as a child is strongly related to psychological problems later in life³⁶. In relation to

³³

[https://www.legislation.gov.uk/ukpga/2021/17/section/3#:~:text=3Children%20as%20victims%20of%20domestic%20abuse&text=\(1\)This%20section%20applies%20where,B%E2%80%9D\)%20is%20domestic%20abuse.&text=\(b\)is%20related%20to%20A%20or%20B.&text=\(b\)the%20child%20and%20the%20person%20are%20relatives.](https://www.legislation.gov.uk/ukpga/2021/17/section/3#:~:text=3Children%20as%20victims%20of%20domestic%20abuse&text=(1)This%20section%20applies%20where,B%E2%80%9D)%20is%20domestic%20abuse.&text=(b)is%20related%20to%20A%20or%20B.&text=(b)the%20child%20and%20the%20person%20are%20relatives.)

³⁴ <https://www.communitycare.co.uk/2021/01/20/want-able-tell-children-everything-keep-family/>

³⁵ https://domesticabusecommissioner.uk/wp-content/uploads/2025/06/dac_bcyp_main-report_V6-DIGITAL.pdf

³⁶ <https://pubmed.ncbi.nlm.nih.gov/33283632/>

this review what we can learn is that we must ask children directly about the abuse, and the Commissioners research highlighted the experience of children as victims, noting:

Their views have often been sidelined or considered secondary to those of adults – sometimes, children had to keep their views hidden or hold on until they could be given a chance to speak³⁷.

Despite the welcome acknowledgment in the DA Act 2021 recognising children as victims of DA, it is acknowledged:

“The Commissioner continues to hear concerns from frontline practitioners about what the legislative change should actually mean and whether the scale of the problem is understood:

“It is empty legislation without funding.”

“We are really unsure how to make changes as the numbers are so high.”

In addition, practitioners have shared numerous examples of some statutory agencies being unaware of the change in legislation, indicating significant gaps in knowledge³⁸.”

Somerset have implemented the following changes to policy and practice for child DA victims since the DA Act 2021:

- Communications around children as victims of domestic abuse.
- Communications plan for the Community Safety Team.
- The Children and Young People Team at Somerset Domestic Abuse Service awarded more resources to increase service delivery
- Counselling for children and young people
- Somerset domestic abuse online training modules have a dedicated section for children, including pregnancy and early years.

Ultimately though the panel welcome the DA Commissioners recommendations within the research, observing that without national recognition and sustainable funding the support and interventions for children will continue to be patchy and their voices will remain unseen and unheard.

13.4 Potential Self-Neglect

Relevant TOR Points:

- *Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each*

³⁷ https://domesticabusecommissioner.uk/wp-content/uploads/2025/04/dac_bcyp_executive-summary_FINAL-WEB-3.pdf

³⁸ https://domesticabusecommissioner.uk/wp-content/uploads/2025/06/dac_bcyp_main-report_V6-DIGITAL.pdf

organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults, particularly policy and practice in response to evidence of self-neglect.

- *Whether professionals explored or had adequate knowledge of the intersections of substance use, mental health and domestic abuse.*

Self-neglect it is a concept that was first defined in the 1950s, and academics observe³⁹ there are many definitions of self-neglect, in addition there is no one theory that can explain self-neglect. The NHS⁴⁰ define self-neglect as an “*extreme lack of self-care*”. Whilst it is acknowledged it can affect older and younger people, the majority of research regarding self-neglect focuses on the older population. In regard to Nicole there was no formal referral for self-neglect, and the panel are careful not to make assumptions on the potential for her situation to be attributed to self-neglect posthumously.

However, it is important to understand more about self-neglect for victims of domestic abuse. Self-neglect can be associated with depression, living alone, poor social networks, economic decline, poor coping skills, and substance use, and many younger people who displayed features of self-neglect portrayed fractured and chaotic life histories with substance use and other health factors being present – academics also acknowledge traumatic life circumstances influenced the way younger and older people coped over time⁴¹.

As with many reviews we only gain a snapshot of what was going on for the victim and there is often no one thread that identifies a reason for when and how things became so bad for them. For Nicole, as mentioned, her life was seemingly “okay” until the latter years – and she obviously held together a family and a job despite being subjected to violence and abuse from Harry. We don't know from the agency data when Nicole's drinking became problematic for her, but she was talking to her GP about getting support for her mental health from November 2020, and she began to engage in conversations with her GP in March 2021 after being diagnosed with a cyst on her pancreas in February 2021. After panel discussion the health representative was able to explain that a pancreatic cyst usually indicates long term alcohol abuse.

When the author and chair spoke to Nicole's employer and friend, they indicated Nicole's drinking significantly worsened during COVID19 (see section 13.5). Their input reveals that Nicole was already struggling with domestic abuse, and she sometimes used alcohol to cope with her feelings. However, the lockdown period exacerbated her drinking and when she returned to work after lockdown ended the impact of substance use made a difference in her performance and presentation. Research⁴² details the COVID19 pandemic saw increased alcohol consumption was extensively documented, particularly amongst people with co-occurring issues of

³⁹ <https://www.darlingtonextra.co.uk/media/kskfladc/1-self-neglect-ethical-considerations.pdf>

⁴⁰ <https://safeguarding-guide.nhs.uk/types-of-abuse-exploitation-and-neglect/s3-15/#:~:text=Sometimes%20self%2Dneglect%20is%20related,there%20is%20no%20direct%20correlation>

⁴¹ <https://www.darlingtonextra.co.uk/media/kskfladc/1-self-neglect-ethical-considerations.pdf>

⁴² <https://pmc.ncbi.nlm.nih.gov/articles/PMC9063034/#s0025>

anxiety and depression. Further the research indicates more women reported an increase in alcohol consumption than men, and recommendations include public health reaching out to people who have previously disclosed anxiety and depression if future pandemics occur.

Once Nicole was diagnosed with alcohol related health issues, the reality of these conditions would have been explained in detail to Nicole, and we know she had some periods where she reported her drinking had ceased or reduced significantly. However, at the end of her life agencies were heavily involved in the safeguarding of her children, largely due to the impact of substance use and mental health issues, including suicide attempts. Although there is no evidence to suggest that professionals were discriminatory towards Nicole in terms of her drinking, there is indication of unconscious bias towards her, this is particularly apparent in the fact that Harry was not challenged about his abusive behaviour by professionals. In addition, studies⁴³ have shown that the link between alcohol and self-neglect is relatively misunderstood, even with professionals with an understanding of alcohol related issues, self-neglect is not as readily considered as an issue when compared to issues like hoarding. It is much more likely that a decision to continue drinking may be deemed to be a lifestyle choice, and thus the interventions afforded in safeguarding terms to those who fall under a category or self-neglect may be missed.

Nicole's story provides us with an opportunity to explore the combination of multiple complex needs in victims of DA and the potential for self-neglecting behaviours to be present because of the numerous traumatic issues the victim is dealing with, including being subjected to childhood and adult abuse. It is of note that the review author found no identified research readily available on the links between victims of intimate partner violence and self-neglecting behaviours, although that is not to say studies do not exist, the concept isn't one that is understood in the specialist domestic abuse sector, and there is a potential for further research to be explored nationally, which the panel will highlight in section 15.3 of the review.

13.5 Observations from Friends and Colleagues

Relevant TOR Points:

- *Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.*
- *Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.*

⁴³ <https://www.communitycare.co.uk/2019/07/24/safeguarding-study-reveals-knowledge-gaps-applying-mca-cases-alcohol-based-harm/>

The review author and chair was able to meet with Nicole's employer (a higher-education setting) from the HR department and her work friend, and their insight was incredibly valuable. Not only did it provide context to the agency data, but Nicole's friend was able to explain who Nicole was as a person and provide a tribute to her.

The input from Nicole's employer was insightful and revealed the importance of workplace interventions for victims of domestic abuse, which the panel noted in Nicole's case was best practice, even though Nicole was frustrated at the disclosure to the police. The employer reflected the following:

Nicole started working with us in 2015 in a part time role and in October 2017 took up a higher position. Sadly, I don't believe that I met Nicole during her time with us but certainly from 2017 until late 2020 there didn't appear to be any concerns in the quality of work.

As everyone is aware, the Covid pandemic forced the College to restrict the number of staff working on-site from April 2020 and the decision was made for teaching to be moved online and delivered remotely from home.

During that period the College highlighted a number of support functions available to staff to help with wellbeing and encouraged teams and managers to find the time to check in and catch up remotely with colleagues. However, I feel people working in education, enjoy the interactions with learners and colleagues on a face-to-face basis and I would suggest that for the majority of staff, home working was challenging. In particular for colleagues whose home life may have been difficult and those colleagues who were isolated.

Concerns regarding Nicole's capability to carry out her role became evident from late 2020 and in particular from when staff began to return to work in April 2021. I know that my team and Nicole managers worked to support Nicole with an action plan to support performance. Sadly, there were concerns with performance and conduct up until Nicole resigned her position from the College in August 2021.

My own personal involvement with Nicole was in 2021 when a manager made me aware that Nicole had come into work with visible bruising and had told colleagues that it was due to her partner/ex-partner. Nicole told colleagues that she had logged a call with the Police but that the Police had not gotten back to her. On being made aware and out of a duty to care to our colleagues, I rang the Police to ask what sort of timeframe people should expect to hear back from them following a report of domestic abuse. The Police checked their records and said they had not had a call logged but as I had reported it, they would now follow up. It is my understanding that Nicole was not happy that we had reported the incident, but I accept that Nicole may not have been in the best place at that stage to accept support.

I don't want how Nicole's career ended with us to not highlight that Nicole was well liked by her colleagues at the College and during her time with us would have affected so many young lives in supporting learners attain qualifications and move into the world of work thanks to her dedication and support.

We were all incredibly sorry to hear the news regarding Nicole and I hope this report can help others in similar circumstances. I would be very interested to understand if there was more as an employer we could have done to support Nicole and provide guidance for future support to colleagues.

Nicole's friend and work colleague provided a more holistic insight into her life and the abuse she was experiencing. Her observations were as follows:

After she and Harry split up... it was awful. Really hard to watch.

Harry was the love of Nicole's life. She gave up everything for him. Harry had problems with money, maybe it was gambling, I don't know. Suddenly, there was no money. She had to sell the house, go on the council list. Her whole lifestyle changed.

She ran a tight ship, even in the new place. But then Harry publicly humiliated her. She stuck by him, even when he met someone else much younger than Nicole and left the family home. Nicole was devastated. That was around the time she started working with us.

Harry flaunted his new relationship all over social media. I think that's when the drinking really started. She'd come to work, and you could see it she was going through heartbreak. I don't even know if they ever divorced. Maybe they did. But she was struggling. She'd go home and have a couple of glasses of wine. That's how it began.

Before that, she didn't drink like that. It was gradual. When his new girlfriend was around, Harry was cruel. Abusive. He'd criticise Nicole, break her heart. I'd say he was a narcissist. I don't use that word lightly I've done a diploma in it. I know the signs. Gaslighting, blame-shifting, public humiliation, using the children it was all there.

I remember being frank with her because I was worried. The signs were slow at first, but once you saw them, you couldn't unsee them. It started with a glass of wine in the evenings. She was under so much pressure, and Harry wasn't making things easy. She confided in me about the abuse she was dealing with.

She started showing bruises. Said she slipped on the patio trying to get the cat in. But the bruises were bad, her whole leg, ankle to thigh, black and blue. It broke my heart. There were inconsistencies in her stories. Still, she came to work, always on time.

COVID was the turning point. During lockdown, we worked from home. On Fridays, we'd have team meetings, and Nicole would be there with wine. It was almost glorified, like a joke. But I didn't find it funny. I was worried. When

we returned to the office, her performance changed. Mistakes she'd never made before. Being alone at home, with no one to regulate her, it made things worse.

She tried to detox a couple of times. I remember her saying she was on a six-week detox. She looked better. But she had underlying health conditions. Then, five or six weeks before she passed away, her children were removed from her care. That's when she gave up.

Their relationship was a push-pull dynamic, the classic cycle of abuse. One minute he was proposing on her doorstep, the next he was cruel. Then silence. Then the cycle started again. I think she went through that so many times. I've seen Harry behave that way with other women too. He likes to shame women publicly.

If I could say anything to agencies, it would be this: intervene earlier. When someone reports violence, take it seriously. Not just for women, for men too. Because when it's ignored, people turn to unhealthy coping mechanisms - drinking, drugs - and that's what happened to Nicole. That's what ultimately led to her death.

If she hadn't been abused, would the drinking have escalated like it did? I don't think so. Nicole had her children taken from her by Harry of all people. Employers need to step in when they see someone struggling with addiction, especially if there's domestic abuse. They need to offer support, a care package. When Nicole lost her job, she was financially ruined. That only added to her anxiety. She just needed someone to help her get back on her feet. Recovery should have been the first step. I think about her a lot and miss her very much.

14 Key findings and Conclusions

In line with the above analysis the following key findings and conclusions can be observed.

Nicole was the primary carer for her children for many years and, despite the abuse she reported experiencing from Harry, maintained employment and managed family and household responsibilities. Agency records identify few concerns relating to Nicole prior to November 2020, when she began discussing symptoms of anxiety and depression with her GP. Significant agency involvement occurred primarily during the latter stages of her life. Available information suggests that Nicole managed a range of personal and family demands for many years before experiencing a deterioration in her mental health, coping capacity, and alcohol use. Her alcohol consumption

increased during the COVID-19 pandemic, and a further decline in her wellbeing was evident following her return to work after lockdown restrictions were lifted.

In contrast, Harry was known to agencies as a perpetrator of domestic abuse against women during the review period. Information indicating abuse was available from several sources over a number of years. In November 2020, Nicole's employer informed police of an incident involving physical violence. In April 2021, Nicole disclosed to professionals that she had experienced 17 years of abuse from Harry. Following an overdose in November 2022, Nicole again linked her circumstances to the abuse she was experiencing. Despite these disclosures and subsequent agency involvement with the family, there is little evidence that Harry's behaviour was directly challenged or that interventions aimed at addressing his abusive behaviour were offered. Similarly, there is no evidence that the children were routinely asked about their experiences of domestic abuse.

The information considered within this review demonstrates a gradual deterioration in Nicole's mental health and increasing alcohol use over time. These difficulties occurred within the context of reported coercive and controlling behaviour and physical violence perpetrated by Harry over many years. While Nicole was signposted to domestic abuse services, there is limited evidence of proactive engagement designed to address the abuse she was experiencing. The review highlights the importance of professional curiosity, evidence-led practice, and proactive safeguarding, particularly in situations where victims may be unable or unwilling to make full disclosures due to fear, coercion, or the impact of controlling behaviour.

Although Nicole did not consistently disclose the extent of the abuse she was experiencing, information available to professionals from her own accounts and from third parties indicated the presence of domestic abuse. Earlier recognition of the significance of this information, together with a more coordinated response, may have provided opportunities to offer additional support and intervention at an earlier stage. By the time agency involvement intensified, Nicole's alcohol dependency and associated health difficulties were well established. Professional attention subsequently focused largely on her alcohol use and perceived parenting capacity, while Harry increasingly assumed responsibility for the day-to-day care of the children despite information known to agencies regarding his history of abusive behaviour.

The review found that Harry's behaviour reflected recognised patterns of coercive and controlling behaviour, alongside physical violence, intimidation, and degradation, which served to exert power and control over Nicole. Information about Harry's behaviour was available from a range of sources, including Nicole herself, her parents, her employer, and agency records relating to abuse against other women.

This review also recognises that individuals experiencing domestic abuse may adopt coping strategies in response to trauma and prolonged victimisation, including the misuse of alcohol or other substances. Where individuals present with multiple and complex needs, there is a risk that professional focus can become concentrated on

the presenting issues, potentially reducing attention to the underlying causes of harm. Maintaining professional curiosity and adopting a holistic, trauma-informed approach are therefore essential to ensuring that opportunities to identify domestic abuse, challenge perpetrator behaviour, and provide effective support to victims and children are not missed.

15 Recommendations

15.2 Single Agency Recommendations

No single agency recommendations are proposed for Avon and Somerset Police. A significant amount of domestic abuse focussed work has taken place within ASP since 2023, and as a result of ongoing improvement initiatives and recommendations from other DHRs. The panel agree that further recommendations would be duplicative of this work. Specific initiatives are:

- Implementation of the DA Matters programme; an evidence based cultural, attitudinal and practice transformation programme, provided by SafeLives specifically for police forces. This programme addresses the issues of empathy/compassion fatigue experienced by officers and starts a cultural shift towards looking beyond the situation presented to officers and using professional curiosity to find out the real situation faced by victims. To date 2,500 front line officers and investigators have received the training. The programme is supported by a force wide network of <80 DA Influencers and ~10 DA Matters trainers. These are individuals, both staff and officers, from ASC who champion and promote the force's domestic abuse approach, influencing change and initiating and supporting improvement activities.
- Publication of an updated version of the force's DA Procedural Guidance with a greater emphasis that anyone can be a victim or perpetrator of domestic abuse and reinforcement of Inspector review for NFA decisions.
- Publication of a specific force Controlling and Coercive Behaviour Domestic Abuse procedure.
- Publication of a force Domestic Abuse Evidence Led Prosecution procedural guidance.
- DASH Guidance has been updated to highlight the importance of professional judgement and officer observations in assessing risk and bite sized briefings on the importance of officer's observations have been delivered.
- There is regular CPD training for officers on Stalking and Controlling and Coercive Behaviour delivered by a force subject matter expert and trainer.
- A force wide focus on quality supervision of investigations with new system-based Supervisor Review template which guides supervisors in their review, ensuring a focus on the suspect, gathering evidence, and safeguarding the victim.
- Development and force wide distribution of a series of videos produced in collaboration with the CPS. The videos were developed to improve investigation

standards, to strengthen victim engagement and to increase prosecution success rates. Each video in the series will focus on a specific area of concern and offer insights from both policing and from a prosecution perspective, along with important, actionable advice to improve case outcomes. The videos cover Evidence Led Prosecutions (including advice and guidance on how to document a victim's level of fear) and Controlling and Coercive behaviour amongst other topics.

- Domestic Abuse case scrutiny panels
- Project Bright Light ⁴⁴ - a new initiative to transform and improve the way ASP addresses domestic abuse through a collaboration with leading academics who are experts in this field. The project will examine how investigations are conducted, how victims are safeguarded and how perpetrators can be disrupted and deterred.

All other single agency recommendations were accepted by the panel and are reflected below:

15.1.1 NHS Somerset ICB:

- Promotion across primary care of the potential for abuse in relationships where partners no longer live together.
- Provide assurance that there is an established process for prompt coding for domestic abuse on victim, children and person causing harm records when information is shared by third party agencies.
- Design guidance on how to consider domestic abuse when dealing with patients over the phone with known history of domestic abuse.
- Use of targeted enquiry to be clearly recorded in notes when someone is known to be experiencing ongoing DA.

15.1.2 Public Health Nursing:

- Improved multi-agency liaison or process following the receipt of SWAST notifications sent to multiple professional agencies following contact and cause for safeguarding concerns.

15.1.3 Somerset NHS Foundation Trust:

- To remind CMHS that patients can be supported to contact the Somerset Domestic Abuse Service during a face-to-face contact.
- To explore with mental health leads best way to enable MH practitioners to gain an understanding of the interrelatedness of domestic abuse, MH and alcohol abuse, utilising a trauma informed approach and being mindful of unconscious bias.
- To remind patient liaison team to use professional curiosity during assessment and can support patients to contact the Domestic Abuse Service whilst in Emergency Department.

⁴⁴ [Project Bright Light | Avon and Somerset Police](#)

15.1.4 Somerset Children's Social Care:

- Ensure as a service that we are recording timely and thorough case notes around all work completed.
- Ensure triangulation and sharing information with partner agencies.
- When working with perpetrators of domestic abuse ensure CSC are challenging their behaviours and exploring the concerns with them.
- When safety planning for children where domestic abuse may be a factor ensuring that one parent is then not weaponising the children over the other parent.

15.1.5 Somerset Council Housing Options and Homelessness Service

- Discuss the importance of thorough notetaking with frontline staff to allow for comprehensive audits where appropriate.
- Encourage a homeless application to be opened immediately where an applicant advises that they are without accommodation

15.2 Multi-Agency Recommendations:

15.2.1 Highlight issues of problematic substance use, mental health and the intersections of risk of suicide for victims of domestic abuse

- Somerset Council Community Safety Team to use Nicole's story to increase frontline professional's understanding of impact of co-occurring issues have on victims of DA accessing support.
- Somerset Victims Authentic Voice panel to be supported by the Somerset Domestic Abuse Service to explore what support victims that have issues linked to mental health, substance use and risk of suicide need. What are the barriers to them getting support? What could be done to improve their experiences?

15.2.2 Children as Victims of Domestic Abuse

- On launch of new Children and Young Peoples service Somerset council to promote the children's element of the service with some targeted comms - specifically around victims can get help for themselves and their children
- CSC to explore the use of multi-agency professionals' meetings, with parents who have had children removed after being subjected to DA - highlighting the risk of potential suicide as part of any CYP plan.
- Somerset Safeguarding Children's board to share the missed opportunities to speak to the children as victims of DA in this review, highlighting importance of professionals applying the Think Family Approach ⁴⁵.

15.2.3 Sharing good practice

⁴⁵ https://somersetsafeguardingchildren.org.uk/wp-content/uploads/2023/05/Effective-Support-for-Children-and-Families_2024_MARCH.pdf

- Somerset Council Community Safety Team and Homes in Somerset to share comms on the good practice of identifying and responding to DA by the Homes in Somerset Housing Officer with multi-agency partners.
- Somerset Council Community Safety Team to gather feedback from Nicole's employers on the good practice of in identifying and responding to Nicole as a victim of DA by sharing her story via the network of organisations within the Somerset Employers Domestic Abuse Toolkit⁴⁶.

15.2.4 Perpetrators

- Somerset Council Community Safety Team to use Nicole's story as a case study, to highlight importance of multi-agency partners challenging perpetrators of DA on their behaviours and encouraging them to access specialist local support at the domestic abuse service and Engage programme for perpetrators.

15.3 National recommendations:

15.3.1 Highlight gap in research for victims of domestic abuse and the intersections of multiple and complex needs and potential self-neglect

- Send the review to SafeLives to highlight need for gap in research to be explored in professional responses to victim/survivors of DA with intersecting issues relating to multiple and complex needs and potential self-neglect.

⁴⁶ <https://somersestdomesticabuse.org.uk/supporting-someone/professionals-toolkit/>

17. Appendix A



TERMS OF REFERENCE FOR REVIEW PANEL DHR 060

1. Introduction

- 1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of a 43-year-old woman. The death is believed to be as a result of natural causes, with possible self-neglect due to substance use. Domestic abuse was a factor in her relationship with her ex-partner.
- 1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

- 2.1 Review the circumstances that led to the death in May 2023 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- 2.2 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.
- 2.3 To produce a report which:
 - summarises concisely the relevant chronology of events including:
 - the actions of all the involved agencies;
 - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
 - analyses and comments on the appropriateness of actions taken;

- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The Review will:

- Focus on the most relevant time period in this case, 1st November 2020 to May 2023.
- For this time period, request detailed Individual Management Reviews (IMR's) by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite responses from any other relevant agencies or individuals identified through the process of the Review.
- Request IMR's include relevant information of any earlier or subsequent incidents or events where the Panel agrees this would be beneficial and informative to the Review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the criminal justice proceedings in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers the victim faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.
 - In regards to children and any potential impact this had ensuring the safeguarding of any children during the review.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults, particularly policy and practice in response to evidence of self-neglect.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Whether professionals explored or had adequate knowledge of the intersections of substance use, mental health and domestic abuse.

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSP Chair)

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency	Representative
Independent Chair	
Safer Somerset Partnership (SC Public Health)	
Somerset Domestic Abuse Service	
Somerset FT NHS	
Somerset CSP	
A&S Police	
ICB	
Housing	
Somerset Children's Social Care team	
South Western Ambulance Service	

This is to be confirmed at the first Review Panel meeting on 03/04/2025

5.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: <https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning>)

5.3 Panel Members will:

- Attend every Panel meeting. When attendance is not possible, provide updates / relevant information in advance of the meeting to the DHR mailbox SomersetDHRs@somerset.gov.uk and Dr Shonagh Dillon, Independent Chair.
- Follow online meeting good practice, enabling focused and productive Panel meetings that respect and honour the victim. Including but not limited to having cameras on throughout and avoiding undertaking other work during meetings.
- Actively participate in meetings, and proactively contribute guidance, expertise and experience to inform the Review.
- Complete actions set at Panel meetings by agreed deadlines.
- Where there is a split between the role of Panel Member and IMR author, work effectively in partnership with their agency's IMR author, ensuring provision of timely and high quality IMR's to inform the Review.
- Proactively and promptly address issues with IMR's raised by the Chair and / or Safer Somerset Partnership.
- Work collaboratively and cooperatively in partnership with the Chair to produce the Overview Report, including timely reviews, edits and comments on drafts.

6 **Outline Plan for DHR** (subject to change depending on information found during the review) – Please note 1 day equates to 7 hours.

February 2025	○ Independent Chair appointed by Safer Somerset Partnership
By March (end of month)	○ Independent Chair establishes ToR and timetable with Safer Somerset Partnership

By April (end of month)	○ First Review Panel meeting (date TBC) ○ IMRs/chronologies to commence
By April (end of month)	○ Liaison with Police, Coroner, relatives and friends
By June (end of month)	○ IMRs (with chronologies) returned (deadline DATE TBC)
By July (end of month)	○ Second Panel Meeting (date TBC)
By August (end of month)	○ Draft report to be circulated via email.
By September (end of month)	○ Third Review Panel Meeting (to agree report and recommendations)
By October (end of month)	○ Overview report to be finalized and submitted to the Safer Somerset Partnership Chair and signed off / sent to Home Office

- 6.1 It is envisaged that this review will take the appointed DHR Chair no more than 13 days (91 hours), (as indicated above).

7 Family Involvement:

- This Review will seek to involve the family, friends, and other relevant people who knew the victim, such as neighbours, and employers.
- With the support and guidance of Panel Members and relevant professionals, e.g., Family Liaison Officers, the Chair will proactively seek to engage family members and other relevant people throughout the Review process, offering them multiple opportunities to be involved.
- Where applicable, family members, including children, will be signposted and / or supported to access specialist and expert advocacy services to support their involvement.
- Involvement may include but is not limited to:
 - choosing a pseudonym for the victim
 - assisting with agreeing the scope of the DHR
 - meeting the Chair, and Panel Members
 - providing information, views and opinions in their preferred format to inform the Review
 - attending Panel meetings
 - reviewing the draft Overview Report, with sufficient time granted for them to do this
 - helping to create and implement change after the Review, including involvement in sharing learning, awareness campaigns and monitoring action plans.
- Unless explicitly directly not to do so by the family, the Chair will provide relevant family members with regular updates using available forms of communication (e.g. letter or email) or in the format agreed with the family member. Updates

may include: progress on the Review, next steps, draft timetable for completion and sharing Review inputs as the Review is ongoing. For example, the Individual Management Reviews (IMRs).

- Where the Chair holds in-person meetings with family, and friends and other relevant people they will be accompanied by either a Panel Member, or an appropriate professional from a relevant agency, such as a social worker or police officer.

8 Liaison with Media

- 8.1 Somerset Council as lead agency for domestic abuse for the Safer Somerset Partnership will handle any media interest in this case.
- 8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

Domestic Homicide Review Executive Summary

Safer Somerset Partnership

Report into the death of Nicole
May 2023

Author – Dr Shonagh Dillon, LLB, DCrimJ
November 2025

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Executive Summary

1. Preface

The independent author, Domestic Homicide Review (DHR) panel and the Safer Somerset Partnership wish to offer their deepest condolences to everyone who was affected by Nicole's⁴⁷ death. We extend our further thanks to those who knew Nicole and contributed to this review, their generosity in doing so, considering their loss, is greatly appreciated.

In addition to this the author and the panel would like to extend our thanks to all professionals who responded to the Individual Management Reviews (IMR), their time and effort enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincere thanks to the panel members for their professionalism and the considered manner in which they approached this review.

2. Pen Portrait and Tribute

Nicole's friend provided valuable insight into who she was as a person. Nicole was deeply committed to her work and devoted to her children, whom she adored. Although the review panel was unable to speak with Nicole's family and was therefore unable to develop a full pen portrait, the tribute shared by her friend offers a heartfelt reflection of Nicole's character, the love she inspired in those around her, and the profound loss felt following her death.

She was such a beautiful, beautiful woman, just a bundle of fun. Warm, energetic, empathic, with the kindest nature. That kindness made her vulnerable, though. People can exploit that kind of goodness.

She absolutely adored her children. I know people say that about mothers, but with her, it was different. They were her world. She was a fun mum, always cooking, always had friends around. Her house was an open door. That's who she was, so warm, so welcoming.

She was laid back in many ways, letting her children be themselves, but she knew when to be firm. Nicole made sure they were well looked after, even while juggling life. She was my friend, and I miss her every day.

⁴⁷ Not her real name

3. Domestic Homicide Review

This review will examine the circumstances surrounding the death of Nicole, aged 43. Nicole's death is believed to be as a result of natural causes. Self-neglect due to substance use was explored within the initial referral for the DHR and in subsequent considerations by the CSP. Most notably, domestic abuse was a concurrent factor in her relationship with her ex-partner until the point of her death.

The combined impact of long-term domestic abuse and coercive and controlling behaviour on Nicole's mental health and substance use is the context within which the panel analysed her tragic death.

The referral from the Somerset Public Health Nursing Safeguarding Service was sent to the CSP on the 02/05/2024. The decision to undertake a DHR was made by the Somerset Safer Partnership on 21/07/2024.

The Home Office was subsequently informed on 31st July 2024. There was a delay prior to commissioning the review in February 2025 due to a lack of available resources. Once resources were secured, a competitive process ensued, and Dr Shonagh Dillon was appointed to undertake the role of independent author and chair to the panel, and the DHR panel was convened. The panel members remained consistent throughout the review and met on the following dates:

- April 2025
- July 2025
- September 2025

2.1 The overview report and executive summary were presented to the Somerset Safer Partnership (SSP) for approval on 22/11/2025 and submitted to the Home Office on 22/12/2025. The report was considered by the Home Office Quality Assurance Panel on 20/05/2026 and the QA subsequently wrote to the CSP to approve publication prior to minor amendments on 06/07/2026. The Home Office Quality Assurance letter, and response to suggested amendments is available in appendix B of the overview report.

4. Contributors to the review and Independence

The chair and author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

Dr Dillon is a Home Office accredited DHR chair and has over three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Nicole or Harry.

The DHR panel consisted of the following agencies and professionals:

Panel Members
Chair and Author – Dr Shonagh Dillon, LLB, DCrimJ
Avon and Somerset Constabulary
Somerset Council - Community Safety Team (on behalf of Safer Somerset Partnership)
Somerset Council - Children's Social Care
NHS Somerset Integrated Care Board
Somerset Council - Housing
Homes in Somerset
Somerset NHS Foundation Trust
Somerset Council - Public Health Suicide Prevention
Somerset Domestic Abuse Service
South Western Ambulance Service NHS Foundation Trust
Somerset Drugs and Alcohol Service

5. Terms of Reference

The Terms of Reference guidance set out the purpose and the scope of the review and the panel focused on the following questions for analysis:

Key Lines of Inquiry DHR

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine if there were any barriers the victim faced in both reporting domestic abuse and accessing services. This should also be explored:
 - Against the Equality Act 2010's protected characteristics.
 - In regard to children and any potential impact this had ensuring the safeguarding of any children during the review.
- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults, particularly policy and practice in response to evidence of self-neglect.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
- Whether professionals explored or had adequate knowledge of the intersections of substance use, mental health and domestic abuse.

The authors of the IMRs are independent in accordance with the Home Office guidance⁴⁸.

The full Terms of Reference are available in Appendix A of the overview report.

6. Facts and background information

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DARDR-Statutory-Guidance-161206.pdf (Section 7)

Nicole was a 43-year-old woman. Seven days prior to her death Nicole had a meeting with a housing officer from Homes in Somerset⁴⁹ and Nicole had visible bruising. Nicole disclosed ongoing abuse from her ex-partner, Harry. Nicole felt her only way out was to die by suicide, and she told the housing officer she had attempted to take her life the week before because of the abuse.

Records show that Nicole and Harry had been separated for eight years but they had stayed in contact with each other due to their three children. Nicole informed the Community Mental Health Team (CMHT) in 2021 that the abuse had been ongoing for 17 years. Nicole explained she hadn't told a lot of people about what Harry had subjected her to over the years, but it is apparent through the data that she began to feel more able to disclose the abuse she had been subjected to by Harry during the latter months of her life. In May 2023 Nicole died suddenly by natural causes attributed to her ongoing alcohol related illnesses and evidence of potential self-neglect. May she rest in peace.

7. Key Findings and conclusions

Nicole was the primary carer for her children for many years and, despite the abuse she reported experiencing from Harry, maintained employment and managed family and household responsibilities. Agency records identify few concerns relating to Nicole prior to November 2020, when she began discussing symptoms of anxiety and depression with her GP. Significant agency involvement occurred primarily during the latter stages of her life. Available information suggests that Nicole managed a range of personal and family demands for many years before experiencing a deterioration in her mental health, coping capacity, and alcohol use. Her alcohol consumption increased during the COVID-19 pandemic, and a further decline in her wellbeing was evident following her return to work after lockdown restrictions were lifted.

In contrast, Harry was known to agencies as a perpetrator of domestic abuse against women during the review period. Information indicating abuse was available from several sources over a number of years. In November 2020, Nicole's employer informed police of an incident involving physical violence. In April 2021, Nicole disclosed to professionals that she had experienced 17 years of abuse from Harry. Following an overdose in November 2022, Nicole again linked her circumstances to the abuse she was experiencing. Despite these disclosures and subsequent agency involvement with the family, there is little evidence that Harry's behaviour was directly challenged or that interventions aimed at addressing his abusive behaviour were offered. Similarly, there is no evidence that the children were routinely asked about their experiences of domestic abuse.

The information considered within this review demonstrates a gradual deterioration in Nicole's mental health and increasing alcohol use over time. These difficulties occurred within the context of reported coercive and controlling behaviour and physical

⁴⁹ <https://www.homesinsomerset.org/>

violence perpetrated by Harry over many years. While Nicole was signposted to domestic abuse services, there is limited evidence of proactive engagement designed to address the abuse she was experiencing. The review highlights the importance of professional curiosity, evidence-led practice, and proactive safeguarding, particularly in situations where victims may be unable or unwilling to make full disclosures due to fear, coercion, or the impact of controlling behaviour.

Although Nicole did not consistently disclose the extent of the abuse she was experiencing, information available to professionals from her own accounts and from third parties indicated the presence of domestic abuse. Earlier recognition of the significance of this information, together with a more coordinated response, may have provided opportunities to offer additional support and intervention at an earlier stage. By the time agency involvement intensified, Nicole's alcohol dependency and associated health difficulties were well established. Professional attention subsequently focused largely on her alcohol use and perceived parenting capacity, while Harry increasingly assumed responsibility for the day-to-day care of the children despite information known to agencies regarding his history of abusive behaviour.

The review found that Harry's behaviour reflected recognised patterns of coercive and controlling behaviour, alongside physical violence, intimidation, and degradation, which served to exert power and control over Nicole. Information about Harry's behaviour was available from a range of sources, including Nicole herself, her parents, her employer, and agency records relating to abuse against other women.

This review also recognises that individuals experiencing domestic abuse may adopt coping strategies in response to trauma and prolonged victimisation, including the misuse of alcohol or other substances. Where individuals present with multiple and complex needs, there is a risk that professional focus can become concentrated on the presenting issues, potentially reducing attention to the underlying causes of harm. Maintaining professional curiosity and adopting a holistic, trauma-informed approach are therefore essential to ensuring that opportunities to identify domestic abuse, challenge perpetrator behaviour, and provide effective support to victims and children are not missed.

8. Recommendations

8.1 Single Agency Recommendations

No single agency recommendations are proposed for Avon and Somerset Police. A significant amount of domestic abuse focussed work has taken place within ASP since 2023, and as a result of ongoing improvement initiatives and recommendations from other DHRs. The panel agree that further recommendations would be duplicative of this work. Specific initiatives are:

- Implementation of the DA Matters programme; an evidence based cultural, attitudinal and practice transformation programme, provided by SafeLives specifically for police forces. This programme addresses the issues of

empathy/compassion fatigue experienced by officers and starts a cultural shift towards looking beyond the situation presented to officers and using professional curiosity to find out the real situation faced by victims. To date 2,500 front line officers and investigators have received the training. The programme is supported by a force wide network of <80 DA Influencers and ~10 DA Matters trainers. These are individuals, both staff and officers, from ASC who champion and promote the force's domestic abuse approach, influencing change and initiating and supporting improvement activities.

- Publication of an updated version of the force's DA Procedural Guidance with a greater emphasis that anyone can be a victim or perpetrator of domestic abuse and reinforcement of Inspector review for NFA decisions.
- Publication of a specific force Controlling and Coercive Behaviour Domestic Abuse procedure.
- Publication of a force Domestic Abuse Evidence Led Prosecution procedural guidance.
- DASH Guidance has been updated to highlight the importance of professional judgement and officer observations in assessing risk and bite sized briefings on the importance of officer's observations have been delivered.
- There is regular CPD training for officers on Stalking and Controlling and Coercive Behaviour delivered by a force subject matter expert and trainer.
- A force wide focus on quality supervision of investigations with new system-based Supervisor Review template which guides supervisors in their review, ensuring a focus on the suspect, gathering evidence, and safeguarding the victim.
- Development and force wide distribution of a series of videos produced in collaboration with the CPS. The videos were developed to improve investigation standards, to strengthen victim engagement and to increase prosecution success rates. Each video in the series will focus on a specific area of concern and offer insights from both policing and from a prosecution perspective, along with important, actionable advice to improve case outcomes. The videos cover Evidence Led Prosecutions (including advice and guidance on how to document a victim's level of fear) and Controlling and Coercive behaviour amongst other topics.
- Domestic Abuse case scrutiny panels
- Project Bright Light ⁵⁰ - a new initiative to transform and improve the way ASP addresses domestic abuse through a collaboration with leading academics who are experts in this field. The project will examine how investigations are conducted, how victims are safeguarded and how perpetrators can be disrupted and deterred.

All other single agency recommendations were accepted by the panel and are reflected below:

8.1.1 NHS Somerset ICB:

⁵⁰ [Project Bright Light | Avon and Somerset Police](#)

- Promotion across primary care of the potential for abuse in relationships where partners no longer live together.
- Provide assurance that there is an established process for prompt coding for domestic abuse on victim, children and person causing harm records when information is shared by third party agencies.
- Design guidance on how to consider domestic abuse when dealing with patients over the phone with known history of domestic abuse.
- Use of targeted enquiry to be clearly recorded in notes when someone is known to be experiencing ongoing DA.

8.1.2 Public Health Nursing:

- Improved multi-agency liaison or process following the receipt of SWAST notifications sent to multiple professional agencies following contact and cause for safeguarding concerns.

8.1.3 Somerset NHS Foundation Trust:

- To remind CMHS that patients can be supported to contact the Somerset Domestic Abuse Service during a face-to-face contact.
- To explore with mental health leads best way to enable MH practitioners to gain an understanding of the interrelatedness of domestic abuse, MH and alcohol abuse, utilising a trauma informed approach and being mindful of unconscious bias.
- To remind patient liaison team to use professional curiosity during assessment and can support patients to contact the Domestic Abuse Service whilst in Emergency Department.

8.1.4 Somerset Children's Social Care:

- Ensure as a service that we are recording timely and thorough case notes around all work completed.
- Ensure triangulation and sharing information with partner agencies.
- When working with perpetrators of domestic abuse ensure CSC are challenging their behaviours and exploring the concerns with them.
- When safety planning for children where domestic abuse may be a factor ensuring that one parent is then not weaponising the children over the other parent.

8.1.5 Somerset Council Housing Options and Homelessness Service

- Discuss the importance of thorough notetaking with frontline staff to allow for comprehensive audits where appropriate.
- Encourage a homeless application to be opened immediately where an applicant advises that they are without accommodation

8.2 Multi-Agency Recommendations:

8.2.1 Highlight issues of problematic substance use, mental health and the intersections of risk of suicide for victims of domestic abuse

- Somerset Council Community Safety Team to use Nicole's story to increase frontline professional's understanding of impact of co-occurring issues have on victims of DA accessing support.
- Somerset Victims Authentic Voice panel to be supported by the Somerset Domestic Abuse Service to explore what support victims that have issues linked to mental health, substance use and risk of suicide need. What are the barriers to them getting support? What could be done to improve their experiences?

8.2.2 Children as Victims of Domestic Abuse

- On launch of new Children and Young Peoples service Somerset council to promote the children's element of the service with some targeted comms - specifically around victims can get help for themselves and their children.
- CSC to explore the use of multi-agency professionals' meetings, with parents who have had children removed after being subjected to DA - highlighting the risk of potential suicide as part of any CYP plan.
- Somerset Safeguarding Children's board to share the missed opportunities to speak to the children as victims of DA in this review, highlighting importance of professionals applying the Think Family Approach⁵¹.

8.2.3 Sharing good practice

- Somerset Council and Homes in Somerset to share comms on the good practice of identifying and responding to DA by the Homes in Somerset Housing Officer with multi-agency partners.
- Somerset council to gather feedback from Nicole's employers on the good practice of in identifying and responding to Nicole as a victim of DA by sharing her story via the network of organisations within the Somerset Employers Domestic Abuse Toolkit⁵².

8.2.4 Perpetrators

- Somerset Council Community Safety Team to use Nicole's story as a case study, to highlight importance of multi-agency partners challenging perpetrators of DA on their behaviours and encouraging them to access

⁵¹ https://somersetsafeguardingchildren.org.uk/wp-content/uploads/2023/05/Effective-Support-for-Children-and-Families_2024_MARCH.pdf

⁵² <https://somersetdomesticabuse.org.uk/supporting-someone/professionals-toolkit/>

specialist local support at the domestic abuse service and Engage programme for perpetrators.

8.3 National recommendations:

- Highlight gap in research for victims of domestic abuse and the intersections of multiple and complex needs and potential self-neglect
- Send the review to SafeLives to highlight need for gap in research to be explored in professional responses to victim/survivors of DA with intersecting issues relating to multiple and complex needs and potential self-neglect.

Appendix A – Action Plan

Action Plan DHR060 (working document subject to changes)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
Promotion across primary care of the potential for abuse in relationships where partners no longer live together.	Local	Promote within ICB safeguard newsletter, GP best practice, supervision and training.	NHS ICB	02.02.2026- added to GP news bulletin. Shared in GP training. Included in training qtr2 26/27	January 2026	Completed May 2026
Provide assurance that there is an established process for prompt coding for domestic abuse on victim, children and person causing harm records when information is shared by third party agencies.	Local	Carry out an audit of records that have MARAC information shared – and share finding with primary care.	NHS ICB	DS -Coding guidance sent out earlier this year supports this but has not yet been audited. DS and JG will audit records - for DA look at response following MARAC notification. Ongoing	January 2026	
Design guidance on how to consider domestic abuse when dealing with patients over the phone with known history of domestic abuse.	Local	Update the Domestic Abuse standard operational guidance to include this guidance.	NHS ICB	22.12.2025. amendments made to SOP, slide deck produced to share at BP, Sup and GP newsletter.	January 2026	Completed December 2025
Use of targeted enquiry to be clearly recorded in notes when someone is known to be experiencing ongoing DA.	Local	Promote within ICB safeguard newsletter, GP best practice, supervision and training.	NHS ICB	18.11.2025 - discussed at SGPET. 02.02.2026- added to GP news bulletin.	January 2026	Completed February 2026

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
Improved multi-agency liaison or process following the receipt of SWAST notifications sent to multiple professional agencies following contact and cause for safeguarding concerns	Local	Explore current process with SWAST and design improvements to ensure cohesive response as multi-agency partners	Public Health Nursing	There is currently an ongoing service review of the PHN county duty systems (two separate incoming points of access for notifications from external partners, including SWASTS for children 0-5 (Health Visitors) and 5-19 (School Nurses)). This is to ensure the information received from external partners is relevant for the service and the processes of triage/analysis is undertaken before it is received by the named health practitioner for the child. This review is ongoing, expected completion by July 2026 and involves liaison with the partner agencies who send information into the service e.g. SWAST. This will help improve the PHN response to information received and	July 2026	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
				mitigate against information being missed		
To remind CMHS that patients can be supported to contact the Somerset Domestic Abuse Service during a face-to-face contact.	Local	Via safeguarding supervision and discussion with service managers	Somerset NHS FT	Discussion had in safeguarding supervision – Contact number for Domestic Abuse Service provided.	January 2026	Completed January 2026
To explore with mental health leads best way to enable MH practitioners to gain an understanding of the interrelatedness of domestic abuse, MH and alcohol abuse, utilising a trauma informed approach and being mindful of unconscious bias	Local	Consider developing a skills session	Somerset NHS FT	Delivery of trauma informed practice training to CMHS rolled out alongside level 3 safeguarding training and existing risk training.	January 2026	Completed January 2026
To remind patient liaison team to use professional curiosity during assessment and can support patients to contact the Domestic Abuse Service whilst in Emergency Department	Local	Via safeguarding supervision and discussion with service managers	Somerset NHS FT	Discussion had in safeguarding supervision with PLT and service managers – visual demonstration given in where to find the 7 minute briefing.	January 2026	Completed January 2026
Ensure as a service that we are recording timely and thorough case notes around all work completed.	Local	Feedback following previous DHR and workshops since 2023	Somerset Children's Social Care		Dec 2025	Completed

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
		have been completed with the wider service. To be revisited in County Managers Meeting.				
Ensure triangulation and sharing information with partner agencies.	Local	Feedback following previous DHR and workshops since 2023 have been completed with the wider service. Social worker spoken to and reflection on findings. To be revisited in County Managers Meeting.	Somerset Children's Social Care		Dec 2025	Completed
When working with perpetrators of domestic abuse ensure CSC are challenging their behaviours and exploring the concerns with them.	Local	Feedback following previous DHR and training since 2023 have been completed with the wider service. To be revisited in County Managers Meeting	Somerset Children's Social Care		Dec 2025	Completed
When safety planning for children where domestic abuse may be a factor ensuring that one parent is then not weaponising the children over the other parent.	Local	Social worker and author have reflected on this matter as part of this process. Share findings of that reflection with wider	Somerset Children's Social Care		Dec 2025	Completed

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
		service, through county Managers meeting.				
Discuss the importance of thorough notetaking with frontline staff to allow for comprehensive audits where appropriate.	Local	Discuss the importance of thorough notetaking with frontline staff to allow for comprehensive audits where appropriate.	Somerset Council Housing Options and Homelessness Service		March 2026	
Encourage a homeless application to be opened immediately where an applicant advises that they are without accommodation	Local	Encourage a homeless application to be opened immediately where an applicant advises that they are without accommodation	Somerset Council Housing Options and Homelessness Service		March 2026	
Multiagency Recommendation						
Somerset Council Community Safety Team to use Nicole's story to increase frontline professional's understanding of impact of co-occurring issues	Local	Somerset council to circulate a learning briefing which highlights the themes of this DHR incorporating unconscious bias	Somerset Council Community Safety Team	Draft template created, to be circulated pending Home Office Quality Assurance	On publication of the review	Completed

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
have on victims of DA accessing support.						
Somerset Victims Authentic Voice panel to be supported by the Somerset Domestic Abuse Service to explore what support victims that have issues linked to mental health, substance use and risk of suicide need. What are the barriers to them getting support? What could be done to improve their experiences?	Local	Authentic voice to explore what support victims with issues linked to mental health, substance use and risk of suicide need. What are the barriers to them getting support? What could be done to improve their experiences? To be fed back to the SDAB for agreement on how to use this information to make improvements.	Somerset Domestic Abuse Service		April 2026	
On launch of new Children and Young Peoples service Somerset council to promote the children's element of the service with some targeted comms - specifically around victims can get help for themselves and their children.	Local	Promotion through Somerset Council website Alerts to multi-agency partners of available training	Somerset Council Community Safety Team	The manager of the Somerset Domestic Abuse Service has delivered service overviews to agencies across Somerset to ensure professionals are aware of the provision. We continue to promote the online training offer through	July 2026	Completed

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
				regular briefings and the website. A new training post is being stood up within the children's partnership to support with training into education settings and health. This will include learning outcomes from DHR's as key features of the training. There are public comms planned to promote the children's and young peoples element of the domestic abuse service. However, the service currently has high numbers of open clients and a waiting list for service provision. Therefore, we have taken a strategic decision to hold these comms and review in Q3 (Oct 2026).		
CSC to explore the use of multi-agency professionals' meetings, with parents who have had	Local	CSC to explore the use of multi-agency professionals' meetings,	Somerset Children's		July 2026	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
children removed after being subjected to DA - highlighting the risk of potential suicide as part of any CYP plan.		with parents who have had children removed after being subjected to DA - highlighting the risk of potential suicide as part of any CYP plan.	Social Care			
Somerset Safeguarding Children's Partnership to share the missed opportunities to speak to the children as victims of DA in this review, highlighting importance of professionals applying the Think Family Approach	Local	SSCP to promote using website/comms and existing training materials	Community Safety Team /SSCP	Add: https://somensetsafeguardingchildren.org.uk/publication/effective-support-for-children-and-families-in-somerset/ To DHR learning brief to highlight learning around missed opportunities and promote the importance of Think family approach.	July 2026	
Somerset Council and Homes in Somerset to share comms on the good practice of identifying and responding to DA by the Homes in Somerset Housing Officer with multi-agency partners.	Local	Via website and internal comms sharing Nicoles story as a template	Homes in Somerset and Somerset Council Community Safety Team	Include good practice in learning briefing on publication. Revisit messaging when training with housing is established and use DHR example as good practice (or review the online training housing)	April 2026	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
Somerset council to gather feedback from Nicole's employers on the good practice of in identifying and responding to Nicole as a victim of DA by sharing her story via the network of organisations within the Somerset Employers Domestic Abuse Toolkit.	Local	Somerset Council to gather feedback from employers, create an article with comms and cascade the information out using the toolkit to promote.	Somerset Council Community Safety Team	To be included in the website review in 26-27. Reference good practice identified by the chair. https://somersestdomesticabuse.org.uk/supporting-someone/professionals-toolkit/ . Include good practice in learning briefing on publication. Revisit messaging when training with professionals is established and use DHR example as good practice (or review the online training)	April 2026	
Somerset Council Community Safety Team to use Nicole's story as a case study, to highlight importance of multi-agency partners challenging perpetrators of DA on their behaviours and encouraging them to access specialist local support at the domestic abuse service, and Engage programme for perpetrators	Local	Somerset Council to work with comms team to ensure a highlight on perpetrators is incorporated into comms plan. Use blogs and awareness raising of Engage programme, and identify responsibility of multi-agency partners in	Somerset Council Community Safety Team	Reactive comms to be delivered in Q1. Planned comms to be reviewed in Q3. Information to be included in the learning briefing upon publication.	April 2026	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome / Effective change
		challenging perpetrators of DA.				
National Recommendations						
Highlight gap in research for victims of domestic abuse and the intersections of multiple and complex needs and potential self-neglect	National	Send the review to SafeLives to highlight need for gap in research to be explored in professional responses to victim/survivors of DA with intersecting issues relating to multiple and complex needs and potential self-neglect.	Somerset Council Community Safety Team	Draft letter populated, to be sent pending Home Office Quality Assurance	On publication of the review	Completed

Appendix B - Home Office Quality Assurance



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2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Heidi Hill
Somerset Council
County Hall
The Crescent
Taunton
TA1 4DY

06 July 2026

Dear Heidi,

Thank you for submitting the Domestic Homicide Review (DHR) report (Nicole) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 20th May 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at
DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
1	Title Page	No amendments required.

2	Contents Page	No amendments required.
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DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Nicole
COMMUNITY SAFETY PARTNERSHIP	Somerset
DATE REVIEWED BY QA BOARD	20 th May 2026
DECISION	Publish with amendments (noting comments below)
GOOD PRACTICE COMMENDED	• Good consideration is given to the decision not to contact the perpetrator, demonstrating a thoughtful and proportionate approach. • The equality and diversity section is strong and well developed. • The analysis is excellent, with a clear victim-centred focus and effective use of relevant research. • The panel is to be commended for involving Nicole's employer, which provides valuable additional insight along with contributions from her friend. These are significant strengths of the review, helping to provide a fuller picture of Nicole's life. • The inclusion of expert analysis is a particular strength, enhancing the panel's consideration of intersecting vulnerabilities. The incorporation of both domestic abuse and suicide prevention expertise is especially notable. • The April 2023 incident is particularly well detailed, clearly evidencing escalating risk, coercive control, suicidal ideation and high-risk domestic abuse indicators shortly before Nicole's death. The inclusion of body-worn video review further strengthens the analysis and supports a deeper understanding of Nicole's lived experience. • The recognition of exemplary housing practice in April 2023 is important and appropriately highlighted.
FEEDBACK FOR FUTURE DHRs	• Please provide details of pseudonyms in future reports to support clarity and transparency. • For future DHRs, there would be benefit in more clearly distinguishing between factual evidence, professional analysis, and broader research commentary. This will help ensure that the victim's voice and the specific circumstances of the case remain central throughout.

3	Pen Portrait	The opening personal reflection is powerful and humanising and helps retain Nicole at the centre of the review. Please consider developing this further into a dedicated pen portrait to provide a fuller understanding of Nicole's life, relationships, strengths.
4	Condolences	No amendments required.
5	Confidentiality and Anonymity	• Please complete the final sentence, as it currently appears incomplete. • It would be helpful to explain how pseudonyms were chosen and whether Nicole's family were involved in selecting her pseudonym.
6	Terms of Reference	• The section relating to self-neglect is thoughtfully framed; however, consideration could be given to strengthening the rationale for exploring self-neglect within the context of domestic abuse, coercive control, trauma, substance use and vulnerability, as this is an important area of emerging safeguarding learning. • Please consider clarifying whether all agencies completed full IMRs or whether some provided chronologies only, and the rationale for this.
7	Equality and Diversity	• The analysis regarding women's suicidal ideation, trauma and domestic abuse is important and evidence informed. However, some of the wider academic discussion could be condensed slightly to maintain focus on how Nicole's protected characteristics affected her access to support, engagement with services and professional responses. • The reference to unconscious bias is appropriate and important. Please ensure the language remains balanced and evidential, clearly distinguishing between identified practice issues and broader systemic learning. • It may also assist to explicitly reference intersectionality here, as this is a significant feature of Nicole's circumstances and the review's learning.

8	Background Information	• Please consider explaining more clearly at the start why this case met the threshold for a DHR, given that the death was believed to be from natural causes with possible self-neglect, and domestic abuse was identified within the relationship. This will help readers understand the reason for the review and improve transparency. • Please consider clarifying the use of the term “natural causes” alongside “evidence of potential self-neglect,” as this may be unclear for readers. • It would also strengthen the section to clearly recognise the combined impact of long-term domestic abuse and coercive control on Nicole’s physical health, mental wellbeing, substance use, and overall vulnerability, as this appears central to understanding the context of her death.
9	Combined Chronology	• The chronology would be clearer if it separated factual events from analysis, especially where reflective comments are included within the timeline. Some of this narrative may fit better in the analysis section.
		• The chronology shows repeated disclosures of coercive control, suicidal thoughts linked to abuse, and increasing vulnerability over time. The review would be stronger if it highlighted these patterns more clearly and showed where there may have been opportunities for earlier multi-agency intervention.
10	Overview	• It may help the review to look more closely at the risks linked to post-separation abuse, coercive control involving children, financial abuse, isolation, and suicidal thoughts, as these are clearly shown in the police overview. • The analysis could also be strengthened by looking more closely at how risk built up over time across repeated incidents. This should include considering Harry’s wider history of domestic abuse with other partners and whether this was used well enough to inform safeguarding responses for Nicole. • It would also be helpful to explore how professional curiosity, evidence-led policing, and proactive safeguarding could have been improved, especially in situations where victims minimise or deny abuse.
11	Analysis	• This section would be stronger if the analysis is kept concise and avoids repeating the chronology. It should focus clearly on what agencies knew, what they did, what they could reasonably have done differently, and how the learning links to the recommendations. • The section on children as victims is important and should remain prominent. Please ensure the report clearly states that children are victims in their own right under the Domestic Abuse Act 2021, and that their voices and experiences were not fully explored.

		The self-neglect section is thoughtful, but it should be carefully worded to avoid any suggestion that Nicole was responsible for her death. The focus should remain on the impact of trauma, domestic abuse, alcohol dependency, and missed opportunities for trauma-informed support.
12	Conclusions	- Please consider making small changes to keep the language neutral and evidence-based. - The section would also be stronger with a clear closing sentence that links the findings directly to the learning and recommendations, particularly in relation to earlier domestic abuse referral, work with perpetrators, recognising children as victims, and providing trauma-informed support for those with complex needs.
13	Lessons learnt and recommendations	- The inclusion of both good practice and clear recommendations throughout the overview sections is positive. The review strikes a good balance between learning and recognising effective practice, without focusing only on failings. To strengthen this further, please ensure all recommendations are clearly set out as SMART actions. This means they should be specific, measurable, achievable, relevant, and time-bound, with clear ownership, timescales, and oversight to support delivery and monitoring. - It would also help to make sure each recommendation clearly links to a specific learning point, and to distinguish between actions for individual agencies and those that require partnership-wide working.
14	Timescales	- Please review the dates in this section, as there appears to be an inconsistency. The report states that the decision to undertake the DHR was made on 21/07/2025, but later says the Home Office was informed on 31 July 2024. - It would also be helpful to explain more clearly the delays between Nicole's death, the referral, the DHR decision, and the commissioning of the review.
15	Involvement of family / friends / community	- Please confirm whether the Home Office leaflet was shared with Nicole's family. - Please clarify whether any attempts were made to engage the children indirectly through safeguarding professionals, or whether their views and experiences were included in the review in another way, given their central role in the case. - The decision not to contact Harry is explained sensitively and appropriately. However, it would be stronger if this was set out in a more formal and evidence-based way, with clear reference to safeguarding risk, trauma-informed practice, and the need to avoid harm to the children and wider family. - Please also correct minor typographical errors and ensure consistent language and grammar throughout the section.

16	DHR contributors	It would also be helpful to confirm whether panel members attended consistently and whether all agencies contributed fully throughout the review, particularly where the learning and recommendations rely on multi-agency input.
17	DHR Panel	No amendments required.
18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.
20	Dissemination	• Please confirm whether there are plans to contact Nicole's family again before publication. If so, please clarify whether they will be consulted on timing (for example, to avoid sensitive dates) and whether support will be offered. • Please confirm whether Nicole's employer and colleague will receive a copy of the report. • Please correct the section numbering. • The section would be stronger if it explained how learning will be put into practice and monitored over time.
21	Action Plan	Some recommendations are not yet fully SMART. Several actions remain broad, without clear, measurable outcomes or evidence of impact. Some recommendations also include dates that have already passed or are marked as "completed" without setting out clear outcomes, evaluation, or evidence that the learning has been embedded. These would be stronger if they set out how progress and impact will be monitored, who is responsible for providing assurance, what evidence will show the action is complete, and how the learning will be sustained over time.
22	Has there been a request to withhold publication? <i>If Yes, include the reason for the request. Is it proportionate and appropriate?</i>	No request to withhold publication. Whilst the review appropriately considers safeguarding concerns regarding the surviving children, the report does not indicate that publication should be withheld. The QA Board noted that consideration should continue to be given to ensuring that the detail included does not inadvertently identify surviving children or place them at risk.

23	Any other comments	- Please note that Harry had given away the cats. It would be helpful to clarify whether the Panel considered the role of pets as potential targets of abuse. - Please also ensure the executive summary reflects the full range of learning identified in the review, particularly in relation to coercive control, children as victims of domestic abuse, multiple and complex needs, and barriers to accessing support.
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Record of amendments from Independent Chair

DHR 060 HO QA response Table

	Report section	QA Feedback	Response
1	Title Page	No amendments	N/A
2	Contents Page	No amendments	N/A
3	Pen Portrait	Develop further into pen portrait	The current tribute is from staff at the school. The report explains we knew very little about Nicole. The section has been amended to reflect what we did know.
4	Condolences	No amendments	N/A
5	Confidentiality and anonymity	- Amend last sentence. - Confirm whether family chose pseudonyms	Sentence amended. Family not involved in the review. Nicole's friend happy with the name, this is now reflected in the review.
6	Terms of Reference	- Consider rationale for exploring self-neglect. - Confirm whether agencies provided both IMRs and Chronologies.	Self-neglect exploration amended.

			Information on which agencies provided IMRS and Chronologies already contained within the review – further sentence added to confirm.
7	Equality and Diversity	- Amend suicide section - Amend unconscious bias language - Input intersectionality	All amended
8	Background Information	- Strengthen in relation to DHR threshold for self-neglect - Reflect language above re: natural causes - Recognise impact of long term CCB/ DA with health needs	All amended
9	Combined Chronology	- Chronology combines factual events and analysis - Reflect the repeated disclosures of DA and health needs.	Amended Amended
10	Overview	- Look at links between post separation abuse, suicidal thoughts and CCB of children - Place in analysis the risk Harry posed built up over time - Reflect professional curiosity opportunities	Amended Amended Amended
11	Analysis	- It would be better to keep concise to reflect what agencies knew and not repeat the chronology	Reviewed

		- Keep children section prominent and ensure children are seen as victims in their own right under DA Act 2021 - Amend self-neglect section re: language	Already within the review Amended
12	Conclusion	- Keep language neutral - Amend closing statement to reflect recommendations	Amended
13	Lessons Learnt and recommendations	- Ensure SMART - Reflect which recommendations are multi-agency	Reviewed via final edit Already contained in the review
14	Timescales	- Inconsistency in date section - Explain delays	Amended Amended
15	Involvement of family and friends	- Confirm HO letter sent - Reflect whether safeguarding professionals consulted for children - Explain formally why Harry not involved re: safeguarding concerns - Correct typos	Amended Amended Amended
16	DHR Contributors	Confirm if panel members attend all or only some meetings	Amended
17	DHR Panel	No amendments	N/A

