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DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Under Section 9 of the Domestic Violence, Crime and Victims Act 2004

AMY

Commissioned by the Domestic Homicide Review Senior Oversight Forum and written by **Independent Chair, Anne Marks**.

FOREWORD – INDEPENDENT CHAIR

It is understood that Amy died as a result of domestic homicide. Amy's family and friends profoundly feel her loss. My heartfelt condolences, and that of the Domestic Homicide Review Panel, go out to them.

Amy is remembered as bringing immense joy and presence to those who knew her well. She was a mother and is known for the unconditional love and affection that she provided. Amy was the eldest of her siblings, and her own mother has recounted to me how Amy took great responsibility and delight as a child in helping to care for them as they grew up. She is sorely missed.

I would like to thank Amy's mother, who spoke to me on behalf of her family, for the contribution she has made to this report. She has critically provided that sense of who Amy was and what mattered to her. Amy's mother also provided photographs of Amy which I shared with the Domestic Homicide Review Panel members, who were tasked in undertaking this work.

A pseudonym has been used in this report, with the agreement of Amy's mother, to preserve her identity. Other names have similarly been given pseudonyms.

I would like to express my gratitude to the Panel for the commitment and sincerity they have given to this work. I would also like to thank those who undertook Individual Learning Reviews within each of the organisations.

Amy suffered the ultimate act of violence by her partner. The threat of harm he posed pre-existed their relationship and chances to intervene were missed. Amy's life and murder highlights the need for organisations and society to radically rethink how to address male violence against women and girls. It is a deep-rooted problem and one that requires a whole-systems approach to bring about change.

Anne Marks

1.1 TERMS OF REFERENCE

1.1.1 **The timeframe for the Review covers the period of one year, to when Amy was murdered.**

1.1.2 **The Terms of Reference are as follows:**

1.1.3 ***Purpose of the Review***

- ***Review the way in which local professionals and organisations that came into contact with Amy, and her child, worked individually and together to safeguard victims.***

- ***Review the way in which local professionals and organisations that came into contact with the alleged perpetrator, Steven, worked individually and together to tackle harmful behaviour and safeguard victims.***

- ***Seek out opportunities for learning regarding the way in which local professionals and organisations work individually and together to safeguard victims and address offending behaviour.***

- ***Consider whether there were any barriers to accessing services and how these could be addressed.***

- ***Identify clearly the lessons to be learned and the actions that are needed to change practice as a result. How and within what timescales this will be progressed, and what is expected to change as a result. Importantly, this will include early learning which should be implemented ahead of the DHR formally concluding and being reported on and is considered key to the impact of the process and how this will be measured. This relates to learning both within and between organisations and agencies.***

- ***Apply identified learning to service responses, including recommended changes to policies and procedures as appropriate.***

- ***Contribute to the prevention of domestic abuse and homicides and improve service responses for all domestic abuse victims and perpetrators through improved working (including strengthened partnership working) and ensure that domestic abuse (and associated abusive behaviour) is identified and responded to effectively at the earliest opportunity.***

- *Contribute to an increased understanding of the impact of domestic abuse; and highlight good practice.*

1.1.4 *Specific issues to be addressed:*

- *Consider issues around information sharing and the accessibility of information to ensure that data and information has been cross-referenced across agencies, and that information is/was shared in a timely manner.*

- *The individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training, duty of candour, etc.) to see whether the homicide indicates that any practice needs to be changed or improved; to support professionals to carry out their work to the highest standards and achieve the best outcome; how and when those changes or improvements will be implemented; and examples of good practice within agencies.*

- *The effectiveness of police and social services response to third party concerns raised to them in relation to a child's welfare.*

- *Ensure a duty of candour principle is expected of and provided by all agencies involved.*

- *Consideration of the use of the Domestic Violence and Abuse Disclosure Scheme.*

- *How do NIPS receive and appropriately share relevant information related to the perpetrator.*

1.1.5 *Timescale for completion:*

The time period for this review is expected to be around 9 months.

1.2 EXECUTIVE SUMMARY

1.2.1 **This Domestic Homicide Review deals specifically with the circumstances surrounding the death of Amy who, it is believed, was murdered by Steven.**

1.2.2 **This report is framed in the recognition that Steven, who is suspected of committing this crime, was never officially prosecuted. Following Amy's murder, Steven ended his life.**

1.2.3 **Amy had been in a relationship with her partner Steven for around a year before her murder. During that time, he had spent four periods in prison custody.**

1.2.4 **Around 6 weeks before Amy's death, Steven and Amy had broken up. However, soon afterwards the relationship resumed.**

1.2.5 **Amy had one child from a previous long-term relationship. Amy and her child lived on their own, with the exception of a brief period of time, around 6 weeks when Steven was in prison, when they lived with his family.**

1.2.6 **Amy had a history of chronic anxiety and depression. During the timeframe under review, Amy was also in contact with her Medical Practice regarding physical ailments.**

1.2.7 **Amy and her child were known to universal health visiting, school nursing, primary school, and social services.**

1.2.8 **During the timeframe under review there were also referrals to PSNI and other HSCT's (Health & Social Care Trusts) where, amongst other matters, childcare concerns were raised. This included on the day of Amy's murder, when a third party had raised child safeguarding concerns to both social services (HSCT 2) and police.**

1.2.9 **Organisations who were providing services to Amy were aware that she was in a new relationship. It was not known who this person was, other than he had been in prison. It transpired at the time of her murder this was Steven.**

1.2.10 **Steven was a known domestic abuser. The threat of harm that he posed to a family member was deemed by organisations as significant. This risk had been discussed at MARAC (a Multi-Agency Risk Assessment Conference). This is a forum where representatives from across a range of organisations develop action plans for increasing the safety of victims deemed at highest risk. He was alerted on police information systems due to this risk he posed toward a family member of his. Steven was also in frequent contact with police for breaches of Non-Molestation Orders and criminality.**

1.2.11 **Just a few months before her murder, Steven had tried to choke Amy. Authorities were unaware of this. The use of Non-fatal Strangulation (NFS) highlights the serious threat he posed.**

1.2.12 **Steven was unemployed and of no permanent address. A choice of housing options was limited given his aggression and abusive behaviour toward housing and hostel staff. He predominantly frequented HSCT 1 area where he grew up, and where his family continued to live.**

1.2.13 Steven had multiple addictions and he was referred for a full mental health assessment. He was known to his GP Medical Practice, Mental Health Emergency Services, Mental Health Unscheduled Care Service, a Drugs Outreach Team, and Healthcare in Prison. He was previously known to Probation Services but was not involved in their service or subject to statutory supervision at the time of Amy's death. Steven was generally uncooperative and missed appointments, so his engagement with services was limited. While Steven had complex needs, this does not excuse the taking of life, and the history of violence and abuse that he perpetrated.

1.2.14 This Review considers why the relationship between Amy and Steven remained unknown to a number of organisations despite the various interactions they had with both parties. It examines what opportunities there are for better collaboration between professionals to identify and manage risk and safeguard those who are vulnerable.

1.3 KEY FINDINGS

1.3.1 A detailed chronology of past events was collated from a wide range of sources including witness testimony and various organisational records, for example medical records, social care case files, criminal investigations/proceedings, and telephone records. This has helped provide an overview of Amy's lived experiences. The following 'Key Findings', are based on those experiences.

Key Finding 1

There were missed opportunities to identify the alleged perpetrator's role in the victim's life.

1.3.3 While there were no reports made by Amy to any of the relevant organisations that Steven was abusing her, there were missed opportunities to intervene and identify risk factors.

1.3.4 A specific concern was raised to HSCT 3 that Amy was in a relationship with a 'prisoner' who was not to be in the company of children. While this was addressed with Amy, and she reported the relationship to be over, there is no evidence that HSCT 3 attempted to establish who this person was and record the information for future reference.

1.3.5 HSCT 1 advised HSCT 3 about other concerns. While some targeted enquiries were made, they were never fully addressed by HSCT 3.

1.3.6 **PBNI also raised concerns to HSCT 3 about information disclosed to them by a third party.**

1.3.7 **While none of the concerns related directly to Steven, a fuller assessment could have potentially led to a better understanding of Amy's experiences, including that a relationship existed.**

1.3.8 **Information was not shared with HSCT 3 by police regarding unrelated incidents they had attended at Amy's home and where Amy's child may have needed the HSCT's services. Had this information been shared, this may have affected the thresholding and decision making around HSCT 3's involvement, and again a clearer picture might have emerged of Amy's situation regarding Steven.**

1.3.9 **There were also incidents involving Amy, Steven, and/or Steven's family that police did not communicate to HSCT 3 either. One example of this was an incident when Amy and child were living with Steven's family. An emergency telephone call was made by a neighbour concerned about the welfare of those inside the home. Attending police did not use their powers of entry to check on the safety of those inside. While information was shared with HSCT 1 by police, this only related to Steven's sibling (who was under 18 years of age) who they knew lived there.**

1.3.10 **Another example was an incident when police attended Amy's home and spoke to Steven who alleged he had been threatened with a knife by an unknown person. He referred to Amy as his girlfriend. Despite a child living in this household, this information was not shared with HSCT 3. This information would have confirmed that the relationship that was reported as over, had in fact resumed. There were several risk factors present in this incident:**

- **Steven was still alerted on police information systems as a 'high-risk' domestic abuser.**
- **Amy said she was not in the home at the time the alleged incident occurred, yet a woman's voice was heard in the background when the initial call was made.**
- **There was reference to a knife.**
- **Steven appeared to be under the influence of drugs and experiencing a paranoid episode.**

3.1.1 **There were missed opportunities to identify risk factors when a third party contacted both police and HSCT 2 on the day that Amy was murdered. That said, the DHR Panel agree this would not have warranted an immediate child protection response as no imminent harm was identified.**

1.3.11 **GPs are also well placed to make targeted enquiry about domestic violence. While Amy had good access to her GP surgery, including throughout the COVID pandemic, her long standing history of chronic anxiety and depression was not fully considered in the context of ongoing domestic violence.**

1.3.12 **Key Finding 2**

System issues: Following a primary referral to the relevant HSCT, all subsequent information received is recorded in an electronic case file and not as a new referral. This means it is more difficult to search and retrieve information in order to inform decision making.

1.3.13 **Databases are powerful tools used across a range of safeguarding organisations to legally store information about service users. This is to inform risk and safeguard those who are vulnerable. To be effective, the information needs to be readily accessible and easy found.**

1.3.14 **The social work information system used in HSCT 3 is the 'Soscare' database. Social workers use this, for example, to record information on children and adults; to alert staff if a child is on the Child Protection Register or is a 'Looked After Child;' and to record assessments, including UNOCINI assessments of children. The Regional UNOCINI software system is designed to capture one referral episode open at any one time. Any new referral information is to be captured in the recording of the UNOCINI or by completing a significant event record (REC4) which allows the instigation of a further child protection investigation.**

1.3.15 **There are five HSCT's in Northern Ireland. While some use the 'Soscare' database, others use an information system called 'Paris.' Accessing information across all five HSCTs is problematic given the variance in the databases used.**

1.3.16 **The Gateway service within HSCT 3 provides a single point of entry (SPOE) for all new referrals. The SPOE triage referrals before a decision is made on whether to transfer the case to a Gateway Locality Team for a UNOCINI initial assessment. This can often mean reviewing other information held.**

1.3.17 **When a decision is taken to forward a new case to the Gateway Locality team an electronic file is created. The file will include the original referral and then any subsequent information/referrals received about the family.**

1.3.18 **In other words, where a case is open and current to a HSCT, all subsequent new information/referrals are recorded in the electronic file.**

1.3.19 **This can impact on thresholding by increasing the opportunity for human error, particularly where less experienced staff are involved in reviewing and accessing the information.**

1.3.20 **In the past all referrals were added to the database meaning a review of the referral history provided all the necessary details. This information was easily retrievable.**

With the introduction of the UNOCINI Framework, the processing of referrals was amended to record only the first referral on Soscare. Subsequent referrals received on an open case were considered as additional information and not reflected in the referral histories.

1.3.21 **Details of referrals, and the number of referrals, are significant indicators of potential risks within families and help to prioritise where an urgent response is required. This has relevance to Amy's situation.**

1.3.22 **Due to a previous low level family support referral, HSCT 3 had an electronic case file open in respect of Amy. Given the nature of the referral the case was placed on a waiting list to be reviewed within the SPOE service.**

1.3.23 **During this time separate referrals were received from anonymous sources. As Amy's case was already open to the Gateway service these referrals were added to the electronic case file and not recorded on the database as new referrals.**

1.3.24 **When Amy's case was reviewed some of the additional information was not analysed in its entirety. This meant the decision not to undertake a full UNOCINI initial assessment was not fully informed. Had all referrals been logged separately on SOSCARE it is possible that a clearer picture of Amy and her child's situation may have emerged, along with an opportunity to address the risks more fully.**

1.3.25 **Of note was a child safeguarding concern raised to HSCT 3 by HSCT 1. There is no evidence this was ever dealt with. There was also a delay of two months in HSCT 1 forwarding this UNOCINI referral in writing to HSCT 3.**

1.3.26 **The DHR Panel has been informed that a new information system called Encompass (not to be confused with Operation Encompass relating to schools and policing) will be introduced into Northern Ireland in 2023. This is a Health and Social Care wide transformation programme which seeks to capitalise on a digitally enabled whole system approach for the delivery of safer, informed care.**

1.3.27 **While this is to be welcomed, the current 'Soscare' process does not adequately support social workers accessing and reviewing referral history in a timely fashion in order to inform risk.**

1.3.28 **<u>Key Finding 3</u>**

There are different dynamics and motivations between Intimate Partner Violence and Adult Family Violence. However, no consideration was given to the fact that this individual, who was alerted as a high-risk domestic abuser for Family Adult Violence, was likely to be a risk to his intimate partner and child.

1.3.29 **Despite being alerted on police information systems as to his 'high-risk' status as a domestic abuser, police never assessed the risk he posed to Amy and her child in this context in any of their dealings with him.**

1.3.30 **Had an assessment taken place, disclosure could have been considered by police under the Domestic Violence and Abuse Disclosure Scheme (DVAD). This is a police service operated scheme that allows victims, or potential victims, make an informed choice on whether they wish to continue in that relationship. It also assists police and partners to manage risk.**

1.3.31 **HSCT 1 attended MARAC meetings and were also aware of Steven's high-risk status. However, this was not communicated to HSCT 3 when they shared information on the incident when Amy and her child were living with Steven's family. Although Steven was in prison custody at that time, he still presented a risk to Amy.**

1.3.32 **Had the connections been made by HSCT 3, that Amy was in a relationship with Steven, a high-risk domestic abuser, disclosure could also have been considered by the HSCT under their child safeguarding responsibilities.**

1.3.33 **In summary, no consideration was given to the fact that Steven, who was violent to family members, was likely to be a danger to others.**

1.3.34 **Key Finding 4**

The need for heightened public awareness of Non-Fatal Strangulation, an act of gender-based violence used to coerce and control victims.

1.3.35 **Non-Fatal Strangulation (NFS) is the compression of the neck to obstruct respiration. It is synonymous with suffocation and choking.**

1.3.36 **Research shows that victims who suffer NFS are seven times more likely to be murdered at some point in the future by those who perpetrate this[1].**

1.3.37 **Victims can experience both physical and psychological effects associated with NFS. Physical effects include loss of consciousness, bladder and/or bowel incontinence, memory loss, motor and speech disorders, difficulty swallowing, breathing, and brain injury. Psychological effects include anxiety, depression, and post-traumatic stress.**

1.3.38 **Obstructing the upper airway can also be fatal. However, NFS should not be regarded as lethal just because it 'could 'accidentally' end as homicide, but because people who use strangulation are more dangerous' (Williams and Monkton-Smith 2020)[2].**

[1] **Glass et al (2008) 'Non-fatal strangulation is an important risk factor for homicide of women'** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2573025/

[2] https://sutda.org/wp-content/uploads/Non-fatal-strangulation-Survey-June-2020-.pdf

1.3.39 **Therefore, NFS in any relationship should be treated as a high-risk indicator, a marker for future behaviour. This was the case with Steven.**

1.3.40 **Amy disclosed that she had awakened with Steven choking her. Professionals were not aware of this. Evidence shows that victims of inter-personal violence, such as NFS, are more likely to disclose to friends or family before reporting the matter to a statutory body.**

1.3.41 **Amy thought that Steven's actions were because of his poor mental health. This is an example of the widely held misinformed view that domestic abuse is 'caused by alcohol and substance misuse or mental health.'[3]**

1.3.42 **NFS is used by perpetrators to exert their control and power over victims. This is relevant in Amy's case. This incident of NFS occurred within a three-week window when Steven was not in prison custody. Up until that point, Steven had been in prison for 5 months, apart from 4 days. Amy had stopped visiting him, in person or virtually, for around four months before this.**

1.3.43 **Until very recently, there was no specific legislation in Northern Ireland to deal with NFS. Perpetrators, if prosecuted, were often charged with a minor assault offence. This did not reflect the nature and seriousness of their offending. In April 2022, the Justice (Sexual Offences and Trafficking Victims) Bill received Royal Assent to become the Justice (Sexual Offences and Trafficking Victims) Act (Northern Ireland) 2022. This legislation includes the 'offence of non-fatal strangulation or asphyxiation.'**

1.3.44 **<u>Key Finding 5</u>**

There was no overarching plan to manage an individual who caused harm within an intimate/family relationship.

1.3.45 **Steven, from his youth, displayed repeated violent, abusive, coercive, and controlling behaviours towards family members. He consistently ignored civil orders and bail conditions imposed on him.**

1.3.46 **However, the nature of his convictions meant that he never met the qualifying criteria (Assault Occasioning Actual Bodily Harm) for his risk to be managed within PPANI. Steven was never convicted for any form of assault relating to domestic violence.**

1.3.47 **Steven was known to MARAC because of the high risk of harm he posed to a family member. The last conference in relation to this victim took place prior to Steven having commenced his relationship with Amy. However, Steven continued to be**

[3] Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together, 2016.

alerted on police systems as to his high-risk status. It is difficult to know how effective this alert was in understanding and assessing his risk towards others, including Amy.

1.3.48 Steven had alcohol and drug addictions. There were some indications of his desire to address his addictions, but he never followed through when services were offered and was uncooperative.

1.3.49 The approach to his overall health needs, including his mental health, was disjointed.

1.3.50 In summary, there was no coordinated joined up approach to targeting and intervening in Steven's harmful behaviours. He was known to the police, children and adult services, health and addiction services, Prisons, Health Care in Prisons, Probation, PPS (Public Prosecution Service), courts, and housing, but all worked in silos with no overarching plan in place to disrupt and limit his harmful behaviour.

1.4 CONCLUSIONS, KEY LESSONS, AND OVERARCHING ACTIONS

1.4.1 Amy was trapped in a relationship with Steven. Steven was controlling, coercive and violent, and he would not allow her to leave. It is understood that this ultimately resulted in her murder.

1.4.2 Amy's murder has led to this Domestic Homicide Review. This Review has allowed the DHR Panel to see things from Amy's perspective, through engagement with her family and others, and not only the narrative provided by organisations.

1.4.3 The Review has established that evidence of Steven's violent and controlling behaviours already existed before his relationship with Amy had commenced. This was not given the importance that it should have been.

1.4.4 Links were not made between the patterns of serious abuse against family members, and the harm that he might pose to Amy and her child. The warning signs were there.

1.4.5 The response to Amy's situation was limited and there were missed opportunities to identify that Steven was part of her life.

1.4.6 Learning Point 1: There were missed opportunities to identify the perpetrator's role in the victim's life, to intervene, and identify risk factors.

1.4.7 Amy never reported to any organisation that Steven was abusing her. However, various organisations were engaged at different points with Amy, Steven, and Steven's family. Better communications between the organisations, fuller assessments, more targeted enquiries, could have potentially led to a better understanding of Amy experiences, including that a relationship with Steven existed.

1.4.8 **Action: To provide an improved collaborative and co-ordinated response to safeguarding, the SPPG (Strategic Planning and Performance Group), HSCT's, and the PSNI to conduct a review of:**

- **The current structures and processes for adult and child safeguarding with a focus on central co-location.**
- **Internal HSCT (x 5) public protection services, and accountability, and how they interface with PSNI PPU's.**
- **The SPPG, HSCT's and PSNI should jointly produce a draft paper within 6 months from the publication of this DHR, outlining a way forward, for implementation within 24 months.**

1.4.9 **Learning Point 2: Ending domestic violence and abuse means effectively dealing with those who abuse.**

1.4.10 **Steven was known to multiple services and was involved in persistent harmful behaviour. However, there was no effective coordinated management of his risk and quality assured interventions. He fell outside existing risk management structures.**

1.4.11 **The Drive Partnership, which works with perpetrators in England and Wales, published a 'Call to Action' in 2020, as part of a Domestic Abuse Perpetrator Strategy. *'Challenging the social norms that facilitate abuse, intervening with those on the cusp of offending, those already causing serious harm, and all stages in between. We want to see systems that enable those who have been abusive or at risk of being abusive to change their behaviour and systems that force them to do so if they are unwilling to change.'* See also the Home Office Policy Paper on Tackling Perpetrators, 31st January 2022. Tackling perpetrators - GOV.UK (www.gov.uk)**

1.4.12 **The learning from this DHR highlights the need for a joined-up approach in Northern Ireland to disrupt abuse and change behaviour of individuals who cause harm in intimate/family relationships. This should be in the form of an overarching strategy with clear pathways involving police, PPS, courts, children and adult services, health and addiction services, Prisons, Health Care in Prisons, Probation, housing, education and importantly, victim's services.**

1.4.13 **Action: In the development of the next Domestic and Sexual Abuse Strategy for Northern Ireland, led by DoJ and DoH, an emphasis is placed on identifying clear pathways for individuals who cause harm within intimate and family relationships. This approach should:**

- **Be based on a multi-agency framework underpinned by core statutory support, and**

- **Involve input from police, children's and adult's services, health, addiction services, courts, housing, probation, victims' services, and education.**

1.4.14 **Learning Point 3: Domestic abuse includes controlling, coercive, and intimidating behaviour that can be perpetrated from prison custody.**

1.4.15 **On the occasions Steven was in prison custody, he telephoned Amy 203 times. At least some of these calls were terminated by Amy straight away. NIPS (Northern Ireland Prison Service) were unaware of the threat of harm that Steven posed to her from prison. While there are joint working arrangements with NIPS to manage and protect victims from unwanted contact by perpetrators who are managed by PPANI, there is no process in place for domestic abusers who fall outside these structures.**

1.4.16 **Action: The development and implementation of an agreed partnership approach to increase the protection and wellbeing of victims and survivors of domestic violence and abuse from unwanted contact from remand and sentenced prisoners who pose a risk of serious harm. This partnership approach should facilitate the effective and timely sharing of information, including relevant information arising from MARAC.**

1.4.17 **<u>Learning Point 4</u>: The social work information systems, as they stand, do not adequately support social workers accessing and reviewing referral history and increases the opportunity for human error, particularly where less experienced staff are involved.**

1.4.18 **Where a case is open and current to the HSCT, all subsequent referrals are recorded on the electronic file under 'significant events.' They are not recorded as a new referral. Social workers reviewing referral history on the database will only see the primary referral that instigated the social work intervention and not any subsequent referrals. This can impact on thresholding.**

1.4.19 **Action: While awaiting the outcome of the HSC Encompass Project:**

- **Additional training to be provided to Gateway staff to reinforce the importance of considering all available information. This includes the 'significant events' section on the E-file to review historical information and enquiries made.**
- **The learning from this DHR will be shared by HSCT 3 with Encompass developers to ensure a regionally agreed approach within the new information technology solution.**

1.4.20 **<u>Learning Point 5:</u> Individuals who cause harm within their family may similarly cause harm to intimate partners despite the different dynamics and motivations.**

1.4.21 **Steven was known to different organisations for the harm he caused within his own family, and the risk he posed to his sibling. No consideration was given to the fact that Steven, while violent within his family, was likely to be a risk to his girlfriend and her child.**

1.4.22 **Action: To enhance the safeguarding of potential victims of high-risk domestic abusers known to MARAC, the MARAC Operational Board (MOB) to review operating guidelines:**

- **With a view to promoting routine enquiry across partner agencies about high-risk domestic abusers and who else they may cause harm to, i.e., within the context of IPV and AFV.**
- **That where another person at risk is identified, collective consideration is given across partner agencies to making a referral for disclosure under the DVAD scheme or, where there is a child, by the relevant HSCT.**

1.4.23 **Action: With due regard to the confines of law, increase the number of domestic history disclosures (DVAD) to victims and/or potential victims. This will assist police and partners to more effectively manage risk.**

1.4.24 **Action: Develop and implement educational interventions based on the Jane Monckton Smith (2021)[4] Eight-Stage Homicide Timeline to support those front-line staff who engage with adults who use coercive control and stalking to abuse others. This training should be extended to supervisors/managers to understand high risk indicators that may lead to murder.**

1.4.25 **<u>Learning Point 6:</u> Heightened public awareness is required of Non-Fatal Strangulation, a high-risk indicator of serious harm. Perpetrators who use NFS are seven times more likely to murder their victim as a result.**

1.4.26 **Amy disclosed that she awakened to Steven choking her. This information was not shared with any professional body. Amy thought that Steven's actions were because of his poor mental health. Domestic abuse is not caused by poor mental health.**

1.4.27 **Action: Develop and implement a public awareness campaign on Non-Fatal Strangulation. This is to increase public knowledge and awareness on the dangers of NFS and provide information to victims of where they can seek help and support.**

1.4.28 **In conclusion, this case underscores the absolute critical need in Northern Ireland for a 'Violence against Women's and Girls Strategy.' One based on prevention, early intervention, supporting victims and survivors, education, and public awareness (at the time of writing, The Executive Office is currently undertaking a 'call for views' exercise to inform the development of such a strategy).**

1.4.29 **This Review also highlights the urgent need for a coordinated strategy across criminal justice agencies, health and social care, housing, and the voluntary sector to tackle the harm that individuals pose within families, and in intimate partner**

[4] 'In Control: Dangerous Relationships and how they End in Murder'.

relationships (at the time of writing the Department of Health and the Department of Justice are undertaking a 'call for views' exercise to inform a follow-up Domestic and Sexual Abuse Strategy for Northern Ireland).

1.4.30 Finally, it is the DHR Panel's intention that organisations will learn from Amy's experiences, so others are protected, and that dangerous behaviours, and patterns of behaviours, are better understood.

APPENDIX A

Overview Recommendations (8)

Agency	Recommendations
Rec. 1 **SPPG** **HSCT(x5)** **PSNI**	**To provide an improved collaborative and co-ordinated SPPG, HSCT's, and the PSNI to conduct a review of:** • **The current structures and processes for adult and child safeguarding with a focus on central co-location.** • **Internal HSCT (x 5) public protection services, and accountability, and how they interface with PSNI PPU's.** • **The current arrangements and structures that support the interview process for children and adults at 'risk of harm' and/or 'adults in need of protection,' with a focus on greater integrated working (not applicable in DHR Amy).** **The SPPG, HSCT's and PSNI should jointly produce a draft paper within 6 months from the publication of this DHR, outlining a way forward, for implementation within 24 months.**
Rec. 2 **DoJ** **DoH**	**In the development of the next Domestic and Sexual Abuse Strategy for Northern Ireland, led by DoJ and DoH, an emphasis is placed on identifying clear pathways for individuals who cause harm within intimate and family relationships. This approach should:** • **Be based on a multi-agency framework underpinned by core statutory support, and** • **Involve input from police, children's and adult's services, health, addiction services, courts, housing, probation, victims' services, and education.**
Rec. 3 **NIPS (Lead)** **PBNI** **PSNI** **HSCT (x5)**	**The development and implementation of an agreed partnership approach to increase the protection and wellbeing of victims and survivors of domestic violence and abuse from unwanted contact from remand and sentenced prisoners who pose a risk of serious harm.** **This partnership approach should facilitate the effective and timely sharing of information, including relevant information arising from MARAC.**
Rec. 4 **HSCT (x5)**	**While awaiting the outcome of the HSC Encompass Project, additional training to be provided to Gateway staff to reinforce the importance of considering all available information. This includes the 'significant events' section on the E-file to review historical information and enquiries made.** **The learning from this DHR will be shared by HSCT 3 with Encompass developers to ensure a regionally agreed approach within the new information technology solution.**

Rec. 5 **MARAC Operational Board**	**To enhance the safeguarding of potential victims of high-risk domestic abusers known to MARAC, the MARAC Operational Board (MOB) to review operating guidelines:** • **With a view to promoting routine enquiry across partner agencies about high-risk domestic abusers and who else they may cause harm to, i.e., within the context of IPV and AFV.** • **That where another person at risk is identified, collective consideration is given across partner agencies to making a referral for disclosure under the DVAD scheme or, where there is a child, by the relevant HSCT.**
Rec. 6 **DOJ** **PSNI**	**With due regard to the confines of law, increase the number of domestic history disclosures (DVAD) made to victims and/or potential victims. This will assist police and partners to more effectively manage risk.**
Rec. 7 **HSCT (x5)** **PBNI** **PSNI**	**Develop and implement educational interventions based on the Jane Monckton Smith Eight-Stage Homicide Timeline to support those front-line staff who engage with adults who use coercive control and/or stalking to abuse others.** **This should also be extended to include their supervisors/managers in order to understand high risk indicators that may lead to murder.**
Rec. 8 **DoJ**	**Develop and implement a public awareness campaign on Non-Fatal Strangulation. This is to increase public knowledge and awareness on the dangers of NFS and provide information to victims of where they can seek help and support.**

APPENDIX B

Agency Recommendations

Agencies involved in this DHR have themselves identified where practice and improvements are needed and, in doing so, have made Recommendations, as follows:

Agency	Recommendations
HSCT 3 Rec. 1	Additional Training for Gateway social work staff. This will cover the following: referral management to include all individual concerns, recording, threshold decision making and analysis of all available information including historical information.
HSCT 3 Rec. 2	The Trust to establish with colleagues in the PSNI a quarterly interface meeting. This should incorporate Safeguarding Service management, operational Gateway management and management staff within PSNI districts in the Trust area.
GP Medical Practice Rec. 1	To develop and implement a Domestic Abuse Policy and associated training to support and empower staff within the surgery to: • Identify and appropriately respond to victims across the spectrum of domestic abuse, including child on parent abuse, • Ask direct questions when it is suspected a person may be subject to violence and abuse, • Understand the links between mental health, addictions, and domestic abuse, • Contribute to wider management of risk of those who perpetrate violence and abuse.
PSNI Rec. 1	To improve the knowledge of and competence in the undertaking and completion of the DASH risk assessment by PSNI officers and staff, to specifically include focus on: - Risk factors and broader assessment of risk (including DVAD consideration) - Professional judgement - Review of DV history - Repeat Referral requirement - to re-refer offence *and* non-offence occurrences where the parties are currently subject to MARAC (HR), back to MARAC, regardless of DASH risk classification. This is to be achieved by: • Review of current SOTP training by identified SME (subject matter expert (in the Police College, and in conjunction with identified SPOC in PPB. This should also include review of relevant Crime Faculty/Investigative training programs. • Delivery of comprehensive Domestic Abuse awareness*, DASH, and MARAC training to all PSNI Student Officers, and first-responding, relevant public-facing roles. This focused training will also be delivered on a mandatory, recurring basis across first-responding, relevant public-facing roles, with additional, alternative awareness training provided across all *other* roles (non-public facing). An *online* training medium is recommended to additionally deliver immediately accessible reference material. * *This training should include specific content on non-intimate, child-on-parent/adult relative domestic abuse.*
PSNI Rec.2	To increase the protection and support provided to:

	- **Children at risk of harm.** **This is to be undertaken by working collaboratively with Health and Social Care partners, enhancing the knowledge and competence of police officers and staff to recognise the occasions when children may be at risk of harm (either in a domestic or non-domestic context), and thereafter to improve the quality, accuracy and timeliness of relevant child protection information recording, retention and sharing with our partners.** **This will be achieved by:** • **Provision of appropriate training encompassing child protections and ACES awareness, as well as the role of, and participant duties at, ICPCCs.** • **Reviewing the process around systems alerts/flagging of CPR nominals.** • **Implementation of a compliance/audit mechanism to mandate swift information sharing at point of service.** • **In occasions of non-domestic occurrences, an alternative technical solution to the PPN, to facilitate timely information sharing (alternative to Form ISF previously referred to as Form 'O').**
PSNI Rec. 3	**To increase the protection and support provided to:** - **Adults at risk of harm and/or in need of protection.** **This is to be undertaken by working collaboratively with Health and Social Care partners, enhancing the knowledge and competence of police officers and staff to recognise the occasions when adults may be at risk of harm (either in a domestic or non-domestic context), and thereafter to improve the quality, accuracy and timeliness of relevant adult protection information recording, retention and sharing with our partners.** **This will be achieved by:** • **Provision of appropriate training encompassing [vulnerable] adult protection awareness*** • **Implementation of a compliance / audit mechanism to mandate swift information sharing at point of service.** • **In occasions of non-domestic reports, a bolt-on or alternative technical solution to the PPN, to facilitate timely information sharing with our partners.** ***Specific attention should be given within the training to enhancing the knowledge of police to recognise vulnerabilities arising from non-intimate, child-on-parent/adult relative domestic abuse.***
PSNI Rec. 4	**Ensure PSNI compliance with PACE (NI) Order 1989 and the Victim Charter, Northern Ireland, in regard to, specifically:** • **Our dealings with detained persons, and** • **Our dealings with victims and witnesses.** **This will be achieved by:** • **Training on the provision and role of appropriate adults and RIs, and** • **Training on the appropriate treatment of and support for victims and witnesses, including those who are considered vulnerable.**
PSNI Rec. 5	**Increase the protection of victims and witnesses from unwanted contact by detained persons.** **This will require implementation of a procedural-based safeguarding mechanism to screen detained persons' nominated contact telephone numbers. This should ensure relevant victims and witnesses are not unduly or unwittingly contacted by detained persons by virtue of detained person contact rights (see PACE Codes of Practice, Code 'C').** **This will be achieved by focused training for custody staff.**
PSNI Rec. 6	**To increase the welfare and support for detained persons and reduce re-offending.** **This will involve the signposting or referring of persons to relevant support services, in particular mental health services. This will specifically focus on, but is not limited to, those persons in police detention.**

	This will be achieved by: • **Implementation, as required, of a referral mechanism for detained persons to relevant support services prior to/upon release.** • **Provision of relevant support service literature at point of release from detention.** • **Consideration of a pre-release DP risk assessment.**
PSNI Rec. 7	**To improve the quality / standard of domestic and / or sexual abuse investigations. This will include specific focus on:** - **Investigative standards and techniques, identifying appropriate offences and core lines of enquiry.** - **Immediate / fast-track actions ('golden hour' principle).** - **Dealing with victims and witnesses of domestic and / or sexual abuse, in their various relational forms** - **Timely consultation and support from PPB specialists.** - **Timely and appropriate use of BWV, in line with the 'McGuinness principles'.** - **Recommended use, management, and enforcement of protective orders, as well as the use of, and compliance with, bail conditions as a protective measure.** - **Identification of those incidents requiring a PPANI1.** **This will be achieved by:** • **Delivery of comprehensive Domestic Abuse training to all PSNI Student Officers and first-responding roles. This focused training should also be delivered on a mandatory, recurring basis to first-responding roles.** • **This should also include consideration of a standardised domestic and / or sexual abuse investigation guide / tactical menu / checklist for investigating officers.**
PBNI Rec. 1	**PBNI to develop and implement a training strategy in relation to adult safeguarding. This will be developed by the Assistant Director (risk) along with PBNI Learning and Development staff and relevant experts from other agencies. The training will be for all operational staff and will be delivered by appropriately skilled trainers. The purpose of the training is to achieve organisational awareness of adult safeguarding issues, signs of abuse or harm (or potential harm), knowledge of onward referrals and actions necessary to protect vulnerable adults.** **The training will include guidance and learning on understanding the threshold for 'risk of harm' overriding 'consent' in relation to adult safeguarding issues, as well as a focus on the dangers of over-reliance on self–report, and the need for consistent professional curiosity.**
PBNI Rec. 2	**Development and implementation of an effective communication plan to ensure that all operational staff make referrals to MARAC using the agreed definition for repeat referrals. This is particularly important in cases where further incidents may not necessarily involve police intervention but could come to the attention of PBNI staff.**
HSCT 2 Rec. 1	**HSC to generate a strategic approach to ensuring that data record systems assist better assessment and decision making and do not restrict effective staff practice and provision of care and treatment with better outcomes for clients and services.**
HSCT 2 Rec. 2	**Review the Trust website to provide clear references to where to seek help in cases of Domestic Violence.**
HSCT 2 Rec. 3	**Ensure that lessons are learned from the errors that happened with Gateway Services.**
HSCT 2 Rec. 4	**Ensure that Gateway staff are clear about Trust Boundaries with neighbouring Trusts to ensure correct response to enquiries and referrals and appropriate signposting to other agencies particularly when performing duty services.**
HSCT 2 Rec. 5	**Review the process for discharge of clients from Trust Drugs Outreach Team and communication to both referrer and GP with a checklist of steps to be taken prior to discharging a high-risk individual from services.**

HSCT 2 Rec. 6	**Review of the Trust Unscheduled Care Child Protection questionnaire to ensure it includes consideration of wider family members.**