2025

# DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

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

## Marcella

Written by Independent Chair, Anne Marks

# FOREWORD: INDEPENDENT CHAIR

I begin by expressing my deepest sympathy to Marcella's family and friends for their tragic loss. Marcella suffered the ultimate act of lethal violence. She was murdered by her intimate partner, although it is suspected they were broken up at the time. Her family's grief is profound.

Marcella leaves behind children. They were not bystanders but instead were systematically exposed to domestic violence and abuse. I am in no doubt their recovery from this experience is made even more difficult as they are now deprived of their mother.

Marcella's relationship with her partner was, from the very outset, dominated by his ongoing physical violence, and controlling and coercive behaviours. Organisations missed opportunities to effectively address and manage the risk that the perpetrator posed to her and did not fully acknowledge the trauma and adversities Marcella's children were experiencing. The response to the family's needs, for protection and support, was inadequate.

I would like to put on record my thanks to Marcella's family for the invaluable contribution they have made to this Review. They have helped enormously by telling us about Marcella, sharing what they knew of her lived experiences, and providing their views on how professional practice can be improved.

Marcella is not her real name. A pseudonym has been used in this report, chosen by her mother, to preserve her identity. Marcella's mother also shared with me a photograph of her daughter that was prominently displayed at all Panel meetings.

I would like to thank the Panel members for their efforts, knowledge, and expertise that they have brought to this work. I extend my appreciation as well to those who undertook Individual Learning Reviews from each of the organisations.

This Review highlights the need to strengthen organisational responses to intimate partner violence, and the critical requirement for professionals to collectively, and effectively, work together and intervene when they suspect a child is at risk.

Anne Marks
Independent Chair

## FOREWORD: MARCELLA'S MOTHER (HER PERSONAL NARRATIVE)

Marcella was my child, and I loved her.

She was a lot like me. In one way, she was quiet but when something had to be said she said it. My husband spoilt her rotten. There was this one day in Woolworth's she lay on the ground screaming because I wouldn't buy her a multi-coloured petticoat. She was a wee girl at the time. My husband picked up the petticoat, went to the till, and bought it. I could see her on the ground watching him with that big smile. I also remember my own father carrying her down the street in his arms despite having the pram with him, just because she wanted him to. She was a right size, and I don't know how he managed it.

As a mummy, Marcella adored her children, despite what she was going through. When her first child came along, if he so much as stared at Marcella from his cot or whimpered she would have gone straight over and lifted him. I remember a time she insisted on taking them all on a family day out on the train. She wouldn't leave any of them behind. Another time, she insisted I made her second son a cake in the form of a wrestling ring because she knew he would love that for his birthday. Just before she died, she had bought blankets. They won't part with them now and bring their blankets to bed. One even tries to smuggle his into his school bag to take with him. One child is the image of her as a child. We have a photograph of Marcella and Santa when she was younger, and you would think it is a recent photograph of her. Her youngest was very attached to Marcella and asks how long she will be in heaven for.

Marcella was spoilt by her siblings, despite always complaining she got less than they did. On her eighteenth birthday, she had her party at her sister's. My son-in-law booked a VIP room in town for her, and I booked a bus to take her and the girls there. They had a great night, but she couldn't walk home in the high-heeled shoes she had worn. We laughed. She used to torture one of her siblings who is good at hairdressing. When she dyed her own hair, and it went wrong, she would have been straight on to them to sort it out. Our children used to laugh on Christmas morning when, having opened her presents, Marcella would ask if there was anything else upstairs, I had forgotten to give her, and on occasions there was.

# EXECUTIVE SUMMARY

This Domestic Homicide Review (DHR) deals with the circumstances surrounding the death of Marcella murdered by Mark (pseudonym). Marcella was murdered in her home. The attack on her was vicious. At the time, it is suspected Marcella and Mark had recently broken up. Mark pleaded guilty to her murder.

Marcella's children were on the Child Protection Register at the time of Marcella's murder. This was because of Mark's violence and abuse, and the potential impact this would have on their wellbeing.

From the very outset of their relationship, Mark was physically violent towards Marcella and attempted to control all aspects of her life. While organisations may not have been fully aware of the extent of this control, testimony provided to this Review outlines how Mark took charge of her finances, listened in on her telephone calls, continually checked on her whereabouts, and influenced what she wore and how she looked. Through regular house moves, Mark also attempted to isolate her from her family.

Marcella came from a strong close-knit family who often provided care and support for Marcella and her children, and a safe space when times were particularly tough. Marcella's family felt they were in that difficult and frustrating position of knowing what Marcella was experiencing, knowing how difficult it was for her to permanently leave Mark because of the physical and psychological control he had over her, yet not wanting to push her into doing things that she did not want to do. They were afraid of losing contact with her altogether. However, the family raised their concerns to professionals at various points, about the violence and abuse that Marcella was being subjected to.

The threat that Mark posed to intimate partners pre-existed his relationship with Marcella. He had a history, and pattern, of persistent harmful behaviour. Professionals did not effectively manage this risk.

The Terms of Reference are as follows:

*Purpose of the Review*

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

- *Review the way in which local professionals and organisations that came into contact with the alleged perpetrator, Mark, 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 that are to be learned and the actions that are needed to change practice as a result, how and within what timescales this will be progressed, what is expected to change as a result (importantly this will include early learning that should be implemented ahead of a 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 lessons to service responses, including changes to policies and procedures as appropriate.*
- *Contribute to the prevention of domestic abuse and homicides and improve service responses for all domestic abuse perpetrators and victims 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 a better understanding of the nature of domestic abuse; and*
- *Highlight good practice.*

*Specific issues to be addressed in the Internal Learning Reviews (ILRs)*

- *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 brought about; and
- *Examples of good practice within agencies.*

# KEY FINDINGS

Key Finding 1

The qualifying criteria was met for the perpetrator to be referred to the Public Protection Arrangements in NI (PPANI) in 2013, to assess and manage his risk. A referral was never made at the time, or in the intervening period.

The Public Protection Arrangements (PPANI) are contained within statutory guidance issued by the Department of Justice under Article 50 of the Criminal Justice (Northern Ireland) Order 2008. PPANI is not a statutory body but rather a structure that enables certain specified agencies to undertake their statutory duties and coordinate their functions to enhance public protection. These arrangements must, by law, be given effect by these agencies, including the Police Service of Northern Ireland (PSNI), the Probation Board for Northern Ireland (PBNI), and the Health & Social Care Trusts (HSCTs). The arrangements require co-operation between these agencies, with particular emphasis on the exchange of information, in order to effectively assess and manage risk posed by relevant offenders[1]. One core function of the arrangements is the identification of a relevant offender in the first instance.

Mark's convictions (Threats to Kill, AOABH) against a former intimate partner meant the qualifying criteria had been reached and the case was automatically eligible for referral into PPANI. Police did not make this referral.

As the qualifying criteria had already been met, further opportunities also presented themselves, both for the police and the HSCT, to refer Mark into PPANI based on 'Current Significant Concerns', i.e. "*where an agency has current evidence of behaviour on the part of an offender that indicates the risk of his/her causing serious harm to another has increased*" (PPANI Manual of Practice). This did not happen.

For the HSCT, given there were concerns of domestic violence and abuse within the relationship, relevant professionals should have consulted with the HSCT's PPANI Principal Officer to ascertain if Mark had a conviction for an eligible offence. Principal Officers have the responsibility to ensure that cases requiring multi-agency risk assessment and management are referred into PPANI, including individuals not already known. This did not happen.

This shows a low level of awareness by police, the HSCT, and supervisors, of:

[1] A relevant offender is defined at Section 3.6 of the statutory guidance which includes a person convicted of a violent offence in domestic or family circumstances.

- PPANI qualifying criteria.
- Structures in place within their own organisation to refer individuals into PPANI.
- Risk indicators; and
- The importance of seeking background information.

An opportunity was also missed by the Probation Board at the Pre-Sentence stage following Mark's conviction for Common Assault on Marcella, to clarify with police whether a PPANI referral had been made. This did not happen.

The best prediction of the future is the past. Had Mark been referred into PPANI at the start, or at any point during the timeframe under review, the likelihood of serious harm being caused to Marcella, or any other potential partner, could have been assessed. Any identified risks would have been addressed through targeted management of risk plans by the relevant organisations.

Assurances have since been provided to the DHR Panel that a referral has now been made to PPANI in respect of Mark. This, unfortunately, is too late for Marcella but may help to prevent the repetition of domestic violence and abuse on any future intimate partners.

Key Finding 2

| Women who are subject to coercive and controlling behaviour, have limited control of their own life, including how they carry out their role as a mother. Professionals did not fully understand this. |
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Domestic abuse is an incident, or series of incidents, of controlling, threatening, and violent behaviour. This is a pattern of behaviour intended to dominate another person by diminishing their confidence and self-esteem. It is designed to make a person dependent on the perpetrator by isolating them from support, exploiting them, depriving them of their free will, and regulating their everyday behaviour[2]. Identifying repeat victims, and repeat perpetrators, as early as possible provides immediate opportunities for organisations to safeguard victims and disrupt abusive and violent behaviour more effectively.

Any parent, whether a father or mother, who is the subject of coercive and controlling behaviour must be given the help, support, and protection they deserve. Overall, statistics show most victims of coercive control are women,

[2] https://www.rcpsych.ac.uk/docs/default-source/events/faculties-and-sigs/general-adult-psychiatry-20/louise-howard.pdf?sfvrsn=b92549db_2

and it remains the case that for many children most parenting responsibilities rest with their mother. This was the case for Marcella.

Marcella's relationship was dominated by a pattern of controlling, coercive, and violent behaviours by Mark. It is understood that:

- Marcella was subjected to serious physical assaults.
- She was assaulted during pregnancy, a high-risk marker of violence and abuse.
- Mark monitored Marcella's everyday life. For example, he used 'facetime' calls to determine and assure himself of Marcella's whereabouts.
- Mark regulated those to whom she could speak. For example, telephone calls from family or professionals usually went unanswered when with him. When she did answer telephone calls, these were often put on loudspeaker.
- He repeatedly put Marcella down in verbal attacks to her and to her family, as evidenced in the run-up to her murder.
- He degraded and humiliated Marcella further by assaulting her in front of other people, and in public.
- He isolated her from family and friends through frequent house moves, and away from the community in which she lived. (Marcella's isolation was, no doubt, further aggravated by COVID restrictions).
- He controlled her finances, for example, by taking what money she had, including money she had borrowed from her family.

Professionals, already under significant pressure in responding to the many individuals and families who require a high-level service, can feel frustrated when victims do not engage fully, or appear obstructive when they do[3]. Not understanding the conditions that a victim of coercive and controlling behaviour is living in, can also lead professionals to conclude they are, in fact, colluding or consenting to the perpetrator's behaviour.

Non-compliance, aggressiveness, evasiveness, avoidance, denial, and other responses to professionals, are not evidence of colluding with a perpetrator, but a means by which a victim of coercive and controlling behaviour can adapt to what is happening and/or prevent matters escalating further[4]. To aggravate the perpetrator could put their life, or the lives or their children, at further risk. This was the case for Marcella.

[3] Devaney, J., Bradbury-Jones, C. Macy, J. (Ed.) et al (2021). 'The Routledge International Handbook of Domestic Violence and Abuse'

[4] CPS Legal Guidance (2017). 'Controlling or Coercive Behaviour in an Intimate or Family Relationship'

Professionals, despite being told by Marcella and family members, did not fully understand the degree and nature of the risk to which Marcella was exposed. Had they recognised the warning signs of coercive and controlling behaviour, this could have allowed them to make more informed decisions about risk assessment and safeguarding. Instead, Marcella, who was subjected to coercive and controlling behaviour, was held responsible for her own and her children's safety. She was not able to do this.

There were times when things were so bad, Marcella did reach out for help. However, professionals did not always recognise the seriousness of the incident as presented, they did not review the history of what had gone on before and did not provide her with the support and assistance she required, for example to help her support a criminal investigation. Opportunities were also missed to invoke bail conditions to further safeguard and support.

One professional, however, must be acknowledged and commended. This is a Family Support Worker who took an innovative approach to Marcella and her situation. This professional worked with Marcella for a brief period prior to her death. She was persistent and undeterred in contacting Marcella when her telephone calls went unanswered and access to the home was denied. To begin with, she encouraged Marcella to meet her in the local park and worked hard at gaining her trust. She focused on offering and providing practical support. Marcella slowly began confiding in this Family Support Worker, eventually showing her a sensory tent in her home that she had made for her child, a side to Marcella that professionals so far had not seen. On the last visit, she opened-up about her loneliness and how she wanted to be free of Mark for good. Marcella spoke positively to her own family about her interactions with this professional and they, in turn, have remarked on the change they noted in Marcella over this period. She began to talk of a future for her and the children, without Mark. Professionals should learn from this.

In summary, Marcella was subjected to ongoing physical violence, and coercive and controlling behaviour. She was neither in a position to protect herself, nor her children. Professionals did not fully understand this.

<u>Key Finding 3</u>

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| Domestic violence and abuse undermine a child's fundamental right for safety and security. The response by organisations to address the children's exposure to this, and improve the environment in which they lived, was inadequate. |

The impact of children's exposure to domestic violence and abuse can be devastating, with detrimental effects on their emotional and behavioural development. Young children can be particularly affected. Prenatal abuse of mothers can also have grave consequences for children, including post-natal trauma, developmental delays, aggression, anxiety, and excessive 'clinging[5].' Marcella's children had witnessed their mother being physically attacked and emotionally maltreated. It is also understood that some of the violence and abuse Marcella suffered took place while pregnant.

Marcella's children were known to the HSCT Children's Services due to concerns about domestic violence and abuse in their home. The children had spent most of their lives on the Child Protection Register as a result. However, little changed for them, and they continued to be exposed to Mark's violent and abusive behaviour.

'The Northern Ireland Review of Children's Social Care Services Report' (June 2023), by Professor Ray Jones, has highlighted the significant pressures experienced by, and increasing demands placed on, Children's Services. These pressures and demands undoubtedly impacted the HSCT Children's Services response in this case, reacting to crises, as opposed to a pre-emptive and initiative-taking approach to address wellbeing, and ensuring the children were safeguarded. The Child Protection Case Conferences (Initial and Review) were, overall, unsatisfactory.

From the point at which HSCT first became involved with the family, the children had a series of social workers. This turnover contributed to missed opportunities in fully understanding and getting to grips with what was happening. Having eventually established that Mark had a history of significant domestic violence and abuse, the HSCT had the power to disclose this to Marcella in keeping with their child safeguarding responsibilities. This did not happen. Nor was this made known to the Family Court. Other serious incidents that were made known to the Family Court did not reflect the nature and seriousness of what had occurred. Communication about the children within and across the HSCT disciplines was also, at times, found wanting.

This was a complex case. All Social Workers need to be equipped to recognise and understand the implications and risk indicators for children and parents living with domestic violence and abuse. The DHR Panel would encourage the Joint Management Group (the Northern Ireland Social Care Council, HSCTs,

[5] Devaney, J., Bradbury-Jones, C. Macy, J. (Ed.) et al (2021). 'The Routledge International Handbook of Domestic Violence and Abuse'

and Universities) to satisfy itself that relevant training is incorporated into all Social Work student training programmes in Northern Ireland.

NIGALA (Northern Ireland Guardian Ad Litem Agency, now known as Children's Court Guardian Agency for Northern Ireland) was appointed to act as an independent voice for the children in the Family Court. The level of contact NIAGALA had with the children, the family, and with the HSCT Children's Services, would seem unacceptable in terms of understanding the needs of the children.

In terms of the police, officers are required to share information with HSCTs on children who may need HSCT services, for example, when attending a domestic related incident, whether the children are present or not. However, there were instances when the HSCT were not informed. There were also occasions when police overlooked the physical welfare of the children.

In terms of the NIAS, more attention or consideration could have been given to the welfare of the children who were present on two occasions they attended.

In summary, the adverse impact of domestic violence and abuse on the children was evident from the outset. This was neither effectively addressed, nor assessed, by the relevant organisations. Had this have happened, this may have led to a better understanding of Marcella's situation.

Key Finding 4

| The perpetrator manipulated professionals and situations to influence decisions. |
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Mark's manipulation of professionals had consequences for Marcella and her children's safety and wellbeing.

He was intimidating, untruthful, made excuses, over-exaggerated, and understated the facts to professionals.

The manipulation of professionals by perpetrators can have significant consequences for risk assessment and risk management. The balance of power and influence must be retained by the professional and not the other way about.

Key Finding 5

The increased need to call out abusive behaviours, and make safe interventions, if the culture within society toward domestic violence and abuse is to change.

Safeguarding victims and arresting perpetrators require community involvement, not just a multi-agency response, if successful results are to be achieved. Reports from members of the public who have witnessed, or who are concerned that someone is suffering from, domestic violence and abuse contribute to professional decision-making, safeguarding, risk management, and evidence gathering in criminal investigations.

In Marcella's case, in addition to her own family members who raised concerns, there were at least five occasions when members of the public, not directly involved in the event itself, reported serious incidents to the police and/or the NIAS. There were a further three occasions when additional information was provided by members of the public because of police enquiries. The DHR Panel acknowledge how upsetting it must have been for those individuals to see and/or hear incidents of violence. The sense of personal responsibility shown by those members of the public who made safe interventions on behalf of Marcella, and who fulfilled their obligations by reporting to a statutory authority, cannot be understated. The DHR Panel are also mindful of the compassion shown by security staff, in commercial premises, who took Marcella into a private area and tended to her injuries following a further assault by Mark.

However, there were individuals who remained passive bystanders during a serious assault on Marcella in her home in front of her children.

In this regard, the DHR Panel welcome bystander intervention training, and other awareness raising approaches, recently introduced into Northern Ireland, and would encourage the Executive Office, in developing the Women's and Girl's Strategy, to continue to build on this.

# CONCLUSION

Marcella had been trapped in a relationship with Mark. Mark was controlling, coercive and violent, and he would not allow her to leave. Marcella was getting stronger and could see a future without him. This led to his control of her diminishing and resulted in her homicide.

The Review has established that evidence of Mark's violent and controlling behaviours existed before he met Marcella. This was not given the importance that it should have been. Over the course of their relationship, links were not made between Mark's patterns of violence and abuse against Marcella. The warning signs were there.

Staff need to be supported by their organisation to deliver the best possible outcomes. The DHR Panel is mindful of all those frontline professionals who worked with Marcella and her children. The Panel acknowledge the impact Marcella's death has had on each one of them and the sadness and grief, undoubtedly, they have experienced.

Domestic violence is everyone's responsibility. It is a child protection issue; an equality issue; and a human rights issue. It is the DHR Panel's intention that organisations will learn from Marcella's experiences, that dangerous behaviours and patterns are more readily identified and appropriate measures adopted in order to better protect others. It is also the DHR Panel's intention that the recommended actions (as outlined in Appendix A and B) will give the public the confidence to continue to come forward, to help victims, knowing that organisations are listening and that changes have been made.

**APPENDIX A**

# Overview Recommendations (10)

| Agency | Recommendations |
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| **Rec. 1**<br><br>**PSNI** | **To mitigate human error and ensure that perpetrators of domestic violence and abuse are appropriately referred to PPANI in a timely manner, an electronic prompt to be added to police information systems alerting officers to review previous qualifying convictions and any 'current significant concerns.'**<br><br>**In the interim, to mitigate associated potential delays arising from the technical development and roll-out of such an information system process, PSNI will support officers and staff with circulation of relevant internal instructional documentation.** |
| **Rec. 2**<br><br>**HSCT** | **To ensure the HSCT supports the Principal Officer to refer relevant individuals into the PPANI, including those not already known, the current pathway and level of PPANI training within the HSCT to be reviewed for their effectiveness. This review should outline, by way of a report, what changes need to happen and how and when these will be implemented.** |
| **Rec. 3**<br><br>**DoJ** | **The Department of Justice (DoJ) to revise and refresh the current Domestic Abuse eLearning package into a shorter version and roll this out to external agencies. Once refreshed and shortened, DoJ will liaise with Northern Ireland Civil Service (NICS) Human Resources (HR) to have it rolled out further across NICS.** |
| **Rec. 4**<br><br>**HSCT** | **As a priority, Child Protection Case Conferences (Initial and Review) are the focus of the next GAIN (Guidelines and Audit Implementation Network) inspection to provide assurances that children on the Child Protection Register, and who are subject to Child Protection Plans, are sufficiently safeguarded. The outcome of this inspection to be reported to the Strategic Planning and Performance Group (DoH).** |
| **Rec. 5**<br><br>**HSCT** | **The existing HSCT training programme on domestic violence and abuse to be reviewed, and made mandatory, in order that relevant frontline staff, and their supervisors:**<br><br>• **Have greater recognition of the significant emotional impact on children, especially pre-school and primary aged children.**<br>• **Fully recognise and understand the behaviours of, and risks to, parents living under coercive and controlling behaviour.** |
| **Rec. 6**<br><br>**HSCT** | **Notification to the Safeguarding Board for Northern Ireland (SBNI) to ascertain if there are further lessons to be learned about the way in which professionals worked together to safeguard children. In other words, to determine whether or not a Case Management Review should be carried out.** |
| **Rec. 7**<br><br>**HSCT**<br><br>**EA**<br><br>**NIAS** | **Multi-agency Working Group to develop and share safe and constructive points for relevant frontline staff to consider that will reduce the likelihood of DV perpetrators manipulating staff and situations. These principles should be tailored towards each organisation's needs and incorporated into guidance and training.** |

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| **PBNI (Lead)**<br><br>**PSNI** | |
| **EXISTING RECOMMENDATIONS FROM PREVIOUS DHRs IDENTIFIED AS RELEVANT TO THIS CASE** | |
| **Rec. 8**<br><br>**(DHR AMY)**<br><br>**HSCT (x5)**<br><br>**PBNI**<br><br>**PSNI** | **Develop and implement educational interventions based on the Jane Monckton Smith (2021)[6] 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.** |
| **Rec. 9**<br><br>**(DHR Ellen)**<br><br>**PPS**<br><br>**PSNI** | **Investigative and prosecution standards, as outlined in the PPS & PSNI Service Level Agreement on Domestic Violence:**<br>• **Are subject to on-going monitoring to ensure compliance,**<br>• **Places a greater focus on victim risk in evidence led prosecutions, including where a victim is unable to engage or has withdrawn their support.** |
| **Rec. 10**<br><br>**(DHR Ellen, DHR Amy**<br><br>**SPPG**<br><br>**HSCT(x5)**<br><br>**PSNI** | **To provide an improved collaborative and co-ordinated response to safeguarding, the HSCB, HSCT's, and the PSNI to conduct a review of:**<br>• **The current structures and processes for adult and child safeguarding with a focus on central co-location.**<br>• **Internal HSCT (x 5) public protection services, and accountability, and how they interface with PSNI PPU's.**<br>• **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.**<br>• **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.** |

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

**APPENDIX B**

| **Agency Recommendations - Agencies involved in this DHR have themselves identified where practices and improvements are needed and, in doing so, have made the following Recommendations:** | |
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| **Agency** | **Recommendations** |
| **HSCT Rec. 1** | **a. Health Visitors will ensure that Routine Enquiry is asked, documented, and actioned in line with their HCHF visits.**<br><br>**The Named Nurse for Safeguarding Children will disseminate a Learning Letter to all Health Visitors and will capture compliance during regular and on-going audit of HV records.**<br><br>**b. Health Visitors will adhere to the Communication Pathways for Midwives, Health Visitors, Family Nurse Partnership Nurses, and School Nurses policy when sharing information from bank Health Visitor to family Health Visitor** |
| **HSCT Rec. 2** | **a. A domestic violence flow chart will be developed within children's social work services. This flow chart will outline what actions to consider in response to domestic abuse cases. This will prompt staff to consider interventions in relation to:**<br><br>**(i) The children**<br><br>**(ii) The adult victim**<br><br>**(iii) The alleged perpetrator.**<br><br>**Prompts will include the need to e.g., obtain a criminal record of alleged perpetrator; complete a DASH form, consider a potential referral to MARAC; consider a referral to the Adult Safeguarding Team, collate social history of victim and alleged perpetrator, safety plan for children and victim; referral to TFSS to address psychological impact of domestic abuse on the children etc.**<br><br>**The flow chart will then be disseminated, displayed in team rooms.**<br><br>**b. Regionally, the Management of Unallocated cases Guidance Paper is being reviewed. This will ensure that unallocated cases are being regularly monitored / reviewed by managers. In the interim HSCT will ensure PSW's / Team Leaders will have oversight of unallocated cases in terms of risk and need and will record this review of the case file record. Managers will report monthly to the Head of Service their overview of these cases.** |

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| | c. There will be annual regular audit cycles within Family and Child Care services of Team Leader supervision with staff to ensure that the risks and needs of domestic violence victims and children are recognised and responded to appropriately.<br><br>d. There will be a specific reflective learning event for the staff / manager from Children's Services regarding the learning from this case in relation to practice and decision making, and a wider Children's Service event ensure the learning / findings from this case is disseminated.<br><br>e. All staff employed within front line Children's Community Services will be required to attend training on Domestic Violence, include MARAC training.<br><br>f. Local Induction for new staff Mental Health Services should include Domestic Abuse Awareness.<br><br>g. HSCT is currently engaged with a voluntary provider to deliver Earlier Help to families waiting statutory assessment / intervention. The provider will deliver a range of early help assessments including where the concerns relate to domestic violence.<br><br>h. The Trust will convene a workshop for lead staff across hospital and community Directorates to agree a Trust approach to Domestic Violence to promote shared understanding and to better support victims of domestic violence.<br><br>i. The Trust Children's Services is represented on the Area Domestic and Sexual Violence Partnership however there is a lack of representation from other key Trust personnel including Mental Health, Emergency Department, and Adult Safeguarding. The Trust to ensure nominations from across these service areas are forwarded to the Partnership Chair so that they can be included in future attendances at the Partnerships Sub-Group and Strategic Advisory Group meetings. |
| Agency | Recommendations |
| EA<br>Rec. 1 | EA to develop Domestic Abuse Awareness training for school Safeguarding teams, including developing cluster group support regionally to allow designated teachers a space to explore issues around domestic violence |
| Agency | Recommendations |
| NIAS<br>Rec. 1 | Review and revise training and protocols for management of domestic abuse and assault calls.<br><br>Targeted training/Poster campaign for NIAS staff on domestic abuse. |
| NIAS<br>Rec. 2 | Improved systems communication including the introduction of DASH assessment into the NIAS patient report software. |
| NIAS<br>Rec. 3 | Review system for placing Information markers to include notifications from partner agencies where there is a risk of domestic abuse. This should include consideration for NIAS becoming a member of MARAC. |
| Agency | Recommendations |

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| **CCGANI Rec. 1** | **Visits to Children and young people: GAL should visit the children in placement at the outset of proceedings and to visit children at sufficient intervals to provide a comprehensive assessment of their needs wishes and views:**<br>• **An audit of the frequency, quality and types of visits (in person/ virtual) made to children and young people as part of the Guardian role, is undertaken to ascertain the compliance with visiting children as set out in the standards of practice.**<br>• **Review the Standards of practice to ensure there is a clear expectation of when and how children are visited with an agreed expectation for all types of cases.**<br>• **Repeat Audit to be undertaken to assess the improvement in visiting of children.**<br>• **Develop a monitoring mechanism for frequency of visits/ engagement with children and young people across all Guardian interventions to monitor the compliance with standards** |
| **CCGANI Rec. 2** | **Initial Analysis Report:**<br>• **Following a meeting with the Judiciary in May 2022 it was agreed that Guardians should use the long Initial Analysis report template which includes the welfare check list. This is the updated guidance for Guardians since June 2022.**<br>• **An audit will be undertaken to ascertain the compliance.**<br>• **Following the workplace domestic abuse policy agreed, training to be provided for Guardians to increase knowledge and awareness and the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021 and CASP-R training.**<br>• **Online HSC/DoJ training mandatory requirement for all staff.**<br>• **Bespoke CCGANI CASP-R Training plan in process.** |
| **CCGANI Rec. 3** | **Guardian Practice Standards:**<br>**Review current standards of practice to clarify and update -**<br>• **Time frame for contact with the Trust following allocation of a case.**<br>• **Time frame for contact with children and family following allocation of the case.**<br>• **Expectations about visits to children and young people.**<br>• **Use of Guardians recording of interventions to evidence the involvement of a Guardian in the case and timeframes.**<br>• **The role of the Guardian in respect of the safety plans within cases and update the standards accordingly.**<br>• **Revision of standards to include updated time frames and expectations, implementing revised standards with Guardians.**<br>• **Update Supervision policy accordingly.**<br>• **Audit of cases to ascertain compliance with the revised standards of practice and expectations of the Guardians.** |
| **Agency** | **Recommendations** |
| **NIHE Rec. 1** | **NIHE Homelessness Policy:**<br>**Development of a Domestic Abuse Policy** |
| **NIHE Rec. 2** | **Provide Domestic Abuse awareness training to frontline staff, including MARAC awareness and DASH training. This will assist front line staff to be cognisant of signs/red flags to enable appropriate signposting and/or reporting of concerns.** |
| **NIHE Rec. 3** | **NIHE Homelessness Policy**<br>**Development of an online monitoring tool for MARAC cases ensuring repeat occurrences are reviewed.** |
| **NIHE Rec. 4** | **NIHE Homelessness Policy**<br>**Improved Partnership working with PSNI (OIU/PPT) HSCT & PBNI regarding High-Risk perpetrators / managed offenders and identification of associated persons at risk in respect of housing.** |

| Agency | Recommendations |
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| PBNI<br>Rec. 1<br><br>(DHR 'Amy' & DHR 'Ellen') | 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.<br><br>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. |
| **Agency** | **Recommendations** |
| PSNI<br>Rec. 1<br><br>(DHR 'Amy' & DHR 'Ellen') | 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:<br><br>- Risk factors and broader assessment of risk (including DVAD consideration)<br>- Professional judgement<br>- Review of DV history<br>- 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.<br><br>This is to be achieved by:<br><br>• Review of current SOTP (Sex Offender Treatment Programme) 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.<br><br>• 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.<br><br>** This training should include specific content on non-intimate, child-on-parent/adult relative domestic abuse.* |
| PSNI<br>Rec.2<br><br>(DHR 'Amy' & DHR 'Ellen') | To increase the protection and support provided to:<br>- Children at risk of harm.<br>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. |

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| | **This will be achieved by:**<br>• **Provision of appropriate training encompassing child protections and ACES awareness, as well as the role of, and participant duties at, ICPCCs.**<br>• **Reviewing the process around systems alerts/flagging of CPR nominals.**<br>• **Implementation of a compliance/audit mechanism to mandate swift information sharing at point of service.**<br>• **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**<br><br>**(DHR 'Amy' & DHR 'Ellen')** | **To improve the quality / standard of domestic and / or sexual abuse investigations. This will include specific focus on:**<br><br>- **Investigative standards and techniques, identifying appropriate offences and core lines of enquiry.**<br>- **Immediate / fast-track actions ('golden hour' principle).**<br>- **Dealing with victims and witnesses of domestic and / or sexual abuse, in their various relational forms**<br>- **Timely consultation and support from PPB specialists.**<br>- **Timely and appropriate use of BWV, in line with the 'McGuinness principles.'**<br>- **Recommended use, management, and enforcement of protective orders, as well as the use of, and compliance with, bail conditions as a protective measure.**<br>- **Identification of those incidents requiring a PPANI1.**<br><br>**This will be achieved by:**<br>• **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.**<br>• **This should also include consideration of a standardised domestic and / or sexual abuse investigation guide / tactical menu / checklist for investigating officers.** |
| **PSNI Rec. 4** | **To improve the quality / standard of:**<br>• **Statement taking related to domestic abuse investigations by focusing on detailed and informative facts, in conjunction with BWV footage and Dash or other approved Risk Assessment.**<br>• **Interview skill and techniques (suspected domestic abuse perpetrators)** |
| **PSNI Rec. 5**<br><br>**(DHR 'Amy' & DHR 'Ellen')** | **Ensure PSNI compliance with PACE (NI) Order 1989 and the Victim Charter, Northern Ireland, in regard to, specifically.**<br><br>- **Our dealings with detained persons.**<br>- **Our dealings with victims and witnesses.**<br><br>**This will be achieved by:**<br><br>• **Training on the provision and role of appropriate adults and RIs, and**<br>**Training on the appropriate treatment of and support for victims and witnesses, including those who are considered vulnerable.** |
| **PSNI Rec. 6** | **To increase the welfare and support for detained persons and reduce re-offending.** |

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| (DHR 'Amy' & DHR 'Ellen') | 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.<br><br>This will be achieved by:<br>• Implementation, as required, of a referral mechanism for detained persons to relevant support services prior to/upon release.<br>• Provision of relevant support service literature at point of release from detention.<br>Consideration of a pre-release DP risk assessment. |
| PSNI Rec. 7 | To review MARAC processes, with a view to improving effectiveness and safeguarding of High-Risk victims. This will involve examining current MARAC processes, and consulting with internal colleagues and external partners to develop best practice.<br><br>This will be achieved by:<br><br>i. Reviewing and improving MARAC referral forms and papers, for consistency and to reduce administrative tasks.<br>ii. Review of repeat referrals, to include cases where victims do not engage, with a view to developing protocol for these cases to ensure victims are safeguarded.<br>iii. Reviewing potential and appropriate actions for each partner agency; development of a key Action List for each partner<br>iv. Standardisation and streamlining of all processes and procedures province wide.<br>Emphasis on appropriate and adequate safeguarding of victims and management of perpetrators. |
| PSNI Rec. 8 | To deliver further training on TecSAFE Emergency Apps for High-Risk victims of domestic and sexual abuse, CSE and Stalking.<br><br>This will be achieved by:<br>i. Delivering refresher training in conjunction with TecSAFE staff for officers previously trained<br>ii. Delivering training in conjunction with TecSAFE staff for officers new to PPB<br>iii. Delivering briefings to public-facing colleagues on the use of TecSAFE and responding to a TecSAFE Vulnerable Caller<br>Liaison with OIU / PPT regarding High-Risk perpetrators / managed offenders and identification of associated persons at risk who may benefit from TecSAFE |
| PSNI Rec. 9<br><br>(DHR 'Amy' & DHR 'Ellen') | To improve the knowledge of and competence in the undertaking and completion of PPANI referrals, to specifically include focus on:<br><br>• Principles underpinning multi-agency assessment and management of risk.<br>• Criteria / threshold for initial assessment<br>• Referral process & obligations<br>• Local Area Public Protection Panels<br>This is to be achieved by:<br>i. Inclusion of above within existing proposed delivery of bespoke DASH and MARAC training to all PSNI Student Officers, as well as all first-responding, relevant public-facing PSNI roles. An *online* training medium is recommended to deliver immediately accessible reference material, which should complement, as necessary, any additional training medium input within Foundation Training (Student Officers).<br>ii. Instructional video briefing (mandatory) to outline and reinforce existing Service PPANI guidance to all police, supported by cascaded officer briefings Service-wide. |