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DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY

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

ELLEN

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

FOREWARD – INDEPENDENT CHAIR

On behalf of myself and the Domestic Homicide Review Panel, I would like to begin by extending my sincere sympathy to Ellen's family, friends, and her community for their loss.

During the course of this Domestic Homicide Review (DHR), we have learned that Ellen was a much-loved mother, daughter, and sister. She was the mother to two children, both of whom she loved dearly. She is remembered as a woman who was courageous, generous, and full of life.

I would like to put on record my thanks to family members for the contribution they have made to this report. They have helped enormously in understanding who Ellen was and in sharing what they knew of her lived experiences.

To protect Ellen's privacy, given the sensitivities and personal information contained within this report, a pseudonym has been used to preserve her identity. A family member chose the name 'Ellen' and agreed with other pseudonyms used. To keep Ellen at the forefront of our mind and the focus of our work, photographs of Ellen were shared with DHR Panel members at Panel meetings.

I would like to recognise the invaluable contribution provided by the DHR Panel members and their extensive experience which they have brought to this work. I extend my appreciation as well to those who undertook Individual Learning Reviews, from each of the organisations, and the efforts they put into this.

This report is an attempt to reflect Ellen's life experiences. It is one dominated for the timeframe under review by violence and abuse inflicted by her adult son. This form of domestic abuse was not fully understood, explored, or recognised by professionals who came into contact with Ellen and her family. This meant she did not have appropriate access to services of support and justice, and her son was never held accountable for his behaviour. Chances to intervene were missed and responses were inadequate.

Child to parent violence must be fully understood by all in order to bring about change. This report will evidence that domestic abuse takes many forms. This includes child/adult to parent violence and inter-family violence. Ellen responded to her son as his mother. She loved him but was worn down by his abusive behaviours.

Anne Marks

1.1 TERMS OF REFERENCE

1.1.1 **The timeframe for the Review covers the period 01/03/17 to Ellen's murder. This period was chosen as it was in 2017 that Thomas' harmful behaviour, including the risk he posed to his sibling, began to cause agencies increasing concern.**

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

1.1.3 ***Purpose of the Review***

- ***Review the way in which local professions and organisations that came into contact with Ellen and her youngest 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, Thomas, 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.*

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

- *Risk identification and information sharing within and across organisations and whether it was underpinned by accurate recording of key information on reports, referrals, IT systems and risk assessments.*

- *The effectiveness of police and social services response to third party concerns raised to them.*

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 Ellen who, it is understood, was murdered by her adult son, Thomas.**

1.2.2 **This report is framed in the recognition that Thomas, who is suspected of committing this crime, was never officially prosecuted.**

1.2.3 **Thomas murdered his mother before ending his life.**

1.2.4 **Ellen had two children, Thomas, who was an adult, and one younger child. Ellen and her youngest child lived on their own. Thomas had no recognised permanent address.**

1.2.5 **Over a number of years Thomas subjected Ellen to physical, emotional, and financial abuse, alongside a high level of coercive control. Thomas regularly stole Ellen's medication, her money, and items from her home to sell.**

1.2.6 **From 2011, Ellen began to raise concerns to professionals about Thomas' harmful behaviours. This included violence towards her, his addictions to drugs, and concerns regarding his mental health.**

1.2.7 **It must be stressed that Thomas' addiction to drugs and poor mental health cannot excuse the taking of life and other acts of violence and abuse that he perpetrated. There is always freewill and choice of behaviours.**

1.2.8 **Such was the extent and level of abuse Ellen was being subjected to by Thomas, she consented to her information being shared with MARAC (Multi-Agency Risk Assessment Conference). This is a forum where representatives from across a range of agencies develop plans for enhancing the safety of victims deemed at highest risk. Following risk assessment, Ellen was identified as 'high risk.' The last conference meeting on Ellen took place in 2019 and Thomas remained, until the time of Ellen's murder, alerted on police systems as a high-risk domestic abuser. This alert had been in place since 2017.**

1.2.9 **The level of risk Thomas posed within the home also resulted in Ellen's youngest child's name being placed on the Child Protection Register. There had been twenty-six referrals made to the Health & Social Care Trust in respect of this child before professionals determined that the threshold of intervention had been met.**

1.2.10 Ellen was known to services over a prolonged period of time relating to concerns about her mental health, as well as a variety of physical conditions. This included ongoing chronic pain. At times there were very low points for Ellen.

1.2.11 Thomas was in frequent contact with police. A number of investigation files were submitted to the Public Prosecution Services (PPS), the majority of which related to breaches of Non-Molestation Orders granted in favour of an extended family member (not Ellen). There were four cases that related to Ellen, one of which he was prosecuted for.

1.2.12 Thomas was committed to prison custody on eight occasions during the period under review. He was previously known to Probation Services but was not involved in their service or subject to statutory supervision at the time of Ellen's death.

1.2.13 From an organisational perspective, this DHR considers how those that worked with Ellen and her family, individually and collaboratively, attempted to support and safeguard her against the risks posed by Thomas, and how they addressed the needs of this family in its entirety. In doing this, this Review seeks to identify opportunities for change and share good practice.

1.2.14 From a societal perspective, this Review also examines and identifies the lessons to be learnt from the dangerous consequences of child on parent violence and what we can do to help protect and support domestic abuse victims and their children.

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 identified a high number of incidents related to Ellen and/or Thomas and has provided an overview of Ellen's lived experiences. The following 'Key Findings' are based on those experiences.

1.3.2 KEY FINDING 1:

> **The need to promote an improved organisational culture where victims of domestic violence and abuse feel listened to, safeguarded, and supported, and where harmful behaviour is effectively managed.**

1.3.3 How professionals engage with service users, colleagues, other teams, and other organisations, is a good indicator of the overall culture.

1.3.4 **Collaborating and sharing information effectively, both internally and across organisations, allows for the early identification of vulnerability, earlier intervention, and better outcomes for victims of domestic violence and abuse.**

1.3.5 **In Ellen's case, medical practitioners, mental health teams and addiction services, to one degree or other, were focused on the health needs of individuals within the family. HSCT (Health & Social Services Trust) Children's Services and Gateway Team were focused on child safeguarding in terms of Ellen's youngest. HSCT Older Peoples Team were focused on supporting an extended family member. Schools were focused on the educational needs of Ellen's youngest child. Criminal justice agencies were focused on Thomas' offending behaviour. Yet missing overall, was that collaborative whole-systems approach to addressing the entire needs of Ellen and her family and managing Thomas' risk. See Key Finding 3 and 5 below.**

3.1.1 **In assessing risk, organisations failed to grasp the bigger picture, the history of what had happened before, Thomas' patterns of harmful behaviour, the dynamics of interpersonal relationships, and effectively failed to view the family through a wide-angled lens. The focus predominantly related to risk as presented at the time. This included third party information HSCT2 and police received on the day that Ellen died. That said, the DHR Panel agree this would not have warranted an immediate response as no imminent harm was identified.**

1.3.6 **Despite her poor health and Thomas's violent and abusive behaviours, it was Ellen who was expected to protect her youngest child and herself; it was Ellen who was expected to keep Thomas out of the home; and it was Ellen who was expected to pursue matters through the criminal justice system. This was not her responsibility, or at least not hers alone.**

1.3.7 **Organisational protocols and systems that enhance and safeguard victims were either not evident, or not fully utilised. Some examples of this are as follows.**

- **The Service Level Agreement between the PSNI and PPS, to improve the quality of investigations and prosecution decision making, was ineffective. Police investigations, and the quality of police files, were generally poor. These affected decisions taken by the PPS.**
- **The HSCT and PSNI 'Protocol for Joint Investigation of Adult Safeguarding Cases' (2016) was never initiated despite Ellen's vulnerabilities and the harm she was suffering. This may have led to a coordinated multi agency response to her needs.**
- **Similarly, despite the various interactions Ellen had with mental health teams and medical professionals, there was no consideration of Ellen's vulnerability viewed within the context of adult safeguarding.**

- **Attending police did not always recognise domestic abuse, resulting in Ellen not being referred to the trauma informed support services provided by Women's Aid. One incident, for example, exemplified professional failure to link 'other crimes' in the context of coercive and/or controlling behaviours.**
- **Thomas, a High-Risk perpetrator of domestic abuse, was able to contact Ellen on numerous occasions from prison custody as there was no system in place to risk assess the appropriateness of this.**
- **In 2018 Safelives, a charity who developed the UK criteria for MARAC referrals, lowered the threshold for re-referral back into MARAC for victims known within the previous 12 months. Member organisations in Northern Ireland adopted this lower thresholding two months after Ellen's murder.**

1.3.8 **There was limited understanding by professionals involved in Ellen's case as to the gravity and impact of child to parent violence. See Key Finding 2 below.**

1.3.9 **Governance structures within and across organisations has meant that relevant policy, procedures, guidance, training, and joint working arrangements have been developed and introduced. These were assumed, on the whole, to be understood by staff, and working effectively in practice. However, there was limited auditing to test whether or not this was the case. Staff need to be equipped with the right skills and support to deliver the best possible outcomes.**

1.3.10 **New thinking is required to address the inherent limitations in the overall system to focus on a more integrated approach to safeguarding victims and managing risk. This is one that actively listens to those who need protection.**

1.3.11 **KEY FINDING 2:**

Limited understanding by professionals of the underlying dynamics and circumstances surrounding child to parent violence.

1.3.12 **The corrosive impact of physical, psychological, emotional, and financial abuse of a mother by her son is only too evident in the trauma that Ellen experienced over many years, not just the timeframe under review.**

1.3.13 **Thomas began perpetrating his abuse as a young adolescent. From a childcare perspective his pattern of harmful behaviours and emergence as a perpetrator was missed.**

1.3.14 **The ongoing erosion of Ellen's mental and physical health is evident in medical records, culminating in her collapse at home three months before her murder.**

1.3.15 **Despite her life experiences, Ellen did everything she could to protect her relationship with her son. For example, during Thomas' extended periods of absence she would seek him out to check on his welfare and visit him while in prison custody.**

1.3.16 **As a mother, Ellen also felt shame, even a sense of guilt about her son's life choices and behaviours, evident when she spoke of her embarrassment following one of many incidents police had attended.**

1.3.17 **Despite the trauma Ellen was experiencing, HSCT 1 expected Ellen to make changes to her behaviour and manage the risk that Thomas posed. For example, safety planning for her youngest child that focused on Ellen keeping Thomas out of the home.**

1.3.18 **The imbalance of power, the fear, and intimidation that Ellen was experiencing was not recognised on many occasions by police. For example, the month before she died police returned Thomas to his mother's home despite him being alerted as a high-risk perpetrator of domestic abuse towards her.**

1.3.19 **On several occasions, no DASH risk identification checklist was completed by attending police. On other occasions they were not completed in a timely fashion. One example was when Ellen telephoned police to report that Thomas was in her home. While on the call, she complained that she could not breathe. A week later she informed an attending officer that on the evening the incident occurred Thomas had her in a head lock. Non-Fatal Strangulation is a high-risk indicator of harm. At this point, Ellen was still alerted on police systems as a High-Risk victim.**

1.3.20 **Of relevance to this is the CJINI recommendation, contained in the 'No Excuse Public Protection Inspection II: A Thematic Inspection of the Handling of Domestic Violence and Abuse Cases by the Criminal Justice System in Northern Ireland' (CJINI, 2019).**

'The PSNI should develop an action plan, within six months of this report, to further develop the approach to dealing with cases of domestic violence and abuse and address the issues highlighted in relation to:

- ***The training and development of new recruits and first responders in the areas of harassment, stalking and coercive and controlling behaviour; and***
- ***The risk assessment practices in cases of domestic violence and abuse.'***

1.3.21 **In terms of other organisations, there are no records the risk posed to Ellen was assessed by Prison services when Thomas was released to her address in 2020. The seriousness was not fully understood by Probation services when Ellen contacted**

their offices to complain that Thomas had turned up at her home, or by the PPS, for example in 2018, when no application was made for a Restraining Order.

1.3.22 **In terms of her health, Medical Practitioners focused on Ellen's mental and/or physical illnesses but largely discounted the impact of trauma and effect of child on parent violence, and the seriousness of this for her own health needs.**

1.3.23 **KEY FINDING 3:**

The need for a more effective whole-systems approach to addressing the needs of Ellen and her family.

1.3.24 **The need for a whole-systems collaborative approach to delivering more complete and sustainable outcomes for families cannot be understated. Sharing information to safeguard and promote wellbeing is vital in this context.**

1.3.25 **Ellen, Thomas, and Ellen's youngest child were known to a range of services, yet partnership working between disciplines and organisations was limited for much of their involvement.**

1.3.26 **For example: -**

- **While there was evidence of regular liaison between HSCT Children's Services and HSCT Adult Services, there was no active working together looking at the holistic needs of the family.**
- **Ellen's mental health was reviewed every 4 to 6 weeks without seeking information from other relevant services she had engaged with.**
- **MARAC members did not appear to have had meaningful engagement with other professionals, including those from their own organisations, who were engaged with Ellen and her family, in order to inform decisions and understand the significant risk that Thomas posed.**
- **There was no communication between the MARAC and the Child Protection Case Conference process, and no consideration given by MARAC to the making of an Adult Safeguarding referral in respect of Ellen.**
- **The HSCT 2 Unscheduled Care Team when assessing Thomas, and the harm he might pose to children, did not consider his sibling, who was known to Children's Services.**
- **There was no reference to MARAC when a decision was made to close Family Support Services to Ellen.**
- **Child safeguarding information relating to Ellen's youngest child was not always shared with the primary and secondary school, or between these schools.**

- **The PSNI and PPS joint approach to an efficient and effective investigation, management and prosecution of reported incidents was limited. For example, domestic violence histories were not included on case files; cases were viewed in isolation; evidence was not secured; and 'special measures' (a series of provisions that help vulnerable and intimidated witnesses give their best evidence in court, as well as helping to relieve some of the stress associated with giving evidence) weren't considered.**
- **DASH risk identification checklists were not always completed by police, or referrals made to Women's Aid. HSCTs were not always informed by police when there were concerns about children.**
- **Probation Services on occasions placed an overreliance on self-reporting and service user consent as opposed to fully understanding GDPR legislation and the need to seek and share information in the 'public interest,' when there is a risk of 'serious crime.'**
- **During a GP consultation in 2017, it was determined that Thomas was afraid of harming his family. No referral was made, or information shared.**

1.3.27 **This presented difficulties in identifying, fully understanding, and intervening in the harm that Ellen, and others, were exposed to, and addressing Ellen's health needs.**

1.3.28 **The Child Protection Case Conference was a platform for representatives across disciplines and organisations to share information. However, key representatives, with critical information, either did not attend or fully contribute to the meetings resulting in poorly informed assessment of Thomas' risk, his offending behaviours and addictions, and an incomplete picture of what the family was experiencing.**

1.3.29 **KEY FINDING 4:**

Police powers to safeguard vulnerable people were not always satisfactorily applied.

1.3.30 **Non-Molestation Orders, Powers of Entry, Duty to Investigate, Powers of Arrest, Bail Conditions, Powers relating to the disposal of police evidence, Powers relating to Detained Persons making phone calls, are just some of the mechanisms available to police to ensure those vulnerable to domestic violence and abuse are protected. These powers were not always satisfactorily applied.**

1.3.31 **For the timeframe under review there were several incidents when offences were disclosed but no investigation took place. There were eleven occasions when Thomas was in breach of an NMO in relation to an extended family member. On four of those occasions no action was taken. There were occasions when Thomas was in breach of his bail conditions where no follow-up action was taken. There were**

occasions when Thomas, while in police custody, contacted Ellen, despite the domestic history, alerts on police information systems, and bail conditions. Finally, two months before Ellen's murder, police returned two knives to Thomas following his arrest, and subsequent conviction, for Possession of an Article with a Blade/Point in a Public Place (Police, having since reviewed the evidence, cannot conclusively say whether either knife was used in Ellen's subsequent murder).

1.3.32 **These legal powers are support mechanisms available to police to ensure victims of domestic violence are safeguarded.**

1.3.33 **KEY FINDING 5:**

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

1.3.34 **Thomas, from his youth, displayed repeated violent, abusive, coercive, and controlling behaviours towards Ellen and others. He consistently ignored civil orders and bail conditions imposed on him.**

1.3.35 **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 (Public Protection Arrangements Northern Ireland). Thomas was never convicted for any form of assault within the domestic setting.**

1.3.36 **Throughout the MARAC process limited attention was given to the management and disruption of Thomas' harmful behaviours. It is difficult to understand, from records reviewed, how effective MARAC was in enhancing Ellen's safety. Having the services of an IDVA (Independent Domestic Violence Advisor) in MARAC could have supported Ellen to engage in the process thereby improving safety planning.**

1.3.37 **Thomas had alcohol and drug addictions. Ellen, and other family members, sought to get Thomas help but with very limited success. There were some indications of his desire to address his addictions, but he never followed through when services were offered. He was uncooperative.**

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

1.3.39 **In summary, there was no coordinated joined up approach to targeting and intervening in Thomas' harmful behaviours. He was known to the police, children and adult services, health and addiction services, Prisons, Health Care in Prisons, Probation, PPS, 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 **This is the first Domestic Homicide Review to be conducted in Northern Ireland. The importance of undertaking this task cannot be underestimated. This review, of the most tragic of circumstances, has provided a rich source of information about the nature of child on parent violence, how organisations failed to work together, and what can be learned from this moving forward.**

1.4.2 **<u>Learning Point 1</u>: Organisations need to promote an improved organisational culture where victims of domestic violence and abuse feel listened to, safeguarded, and supported, and where harmful behaviour is more effectively managed.**

1.4.3 **Reviewing all the interactions that organisations had with Ellen (and other family members) there were many inconsistencies in terms of approach.**

1.4.4 **Statutory responsibilities to safeguard those who are vulnerable were not always applied.**

1.4.5 **Organisational policy, procedures, guidance, joint working arrangements, and training, were assumed, on the whole, to be working. Yet auditing and governance to test whether or not they were applied or working in practice was limited.**

1.4.6 **Action: Undertake periodic assessment of organisational culture relating to domestic violence and abuse measuring:**

- **Values and behaviours.**
- **Standards i.e., that Domestic Violence policy, procedures, joint working arrangements and training are in place and are working effectively in practice.**

1.4.7 **Action: Investigative and prosecution standards, as outlined in the PPS & PSNI Service Level Agreement on Domestic Violence:**

- **Are subject to on-going monitoring to ensure compliance,**
- **Places a greater focus on victim risk in evidence led prosecutions, including where a victim is unable to engage or has withdrawn their support.**

1.4.8 **<u>Learning Point 2</u>: Improved collaboration both internally and across organisations, enables early identification of vulnerability, earlier intervention, and better outcomes for victims of domestic violence.**

1.4.9 **Ellen and her family were known to a range of services, yet partnership working, including information sharing, within and across organisations was limited. This presented difficulties in identifying, fully understanding, and addressing the safeguarding needs of Ellen and the risks that she, and others, were exposed to.**

1.4.10 **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 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.**
- **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.**

1.4.11 **Action: EA Child Protection Support Services (CPSS) will engage through its training programme for Designated Teachers, Governors, Schools, and EA staff, to facilitate learning on the importance of recording and sharing relevant child protection and safeguarding information. This will help inform staff about pupils who are living with domestic violence and abuse, enabling a more supportive response.**

1.4.12 **<u>Learning Point 3</u>: Ending domestic violence and abuse means effectively dealing with those who abuse.**

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

1.4.14 **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)**

1.4.15 **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 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.**

1.4.16 **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.**

1.4.17 **Learning Point 4: Victims involved in MARAC often require enhanced support in order to engage and help inform safety planning.**

1.4.18 **Despite Ellen's involvement in MARAC, her vulnerability and lived experiences were not grasped. Neither was Ellen in a position to fully articulate those. Ellen crucially needed someone to advocate for her.**

1.4.19 **The domestic and sexual abuse advocacy service, primarily for victims of domestic and sexual abuse, is provided by ASSIST NI. This service was introduced approximately six months ago (at the time of drafting this report).**

1.4.20 **Trained advocates offer impartial support; general advocacy; practical support; and information to those victims who have reported a crime to the police, are accessing the vital services of the Rowan Sexual Assault Centre or have been referred from MARAC.**

1.4.21 **Since this service was introduced into Northern Ireland, a minimal number of victims have been referred to/from MARAC.**

1.4.22 **Action: The use of advocacy services to engage, and support victims pre, during, and post MARAC referral. The effectiveness of this engagement and support should be reviewed within 12 months from the publication of this DHR.**

1.4.23 **Learning Point 5: Domestic abuse includes controlling, coercive, and intimidating behaviour that can be perpetrated from prison custody.**

1.4.24 **On the occasions Thomas was in prison custody, he telephoned Ellen at least 398 times. NIPS (Northern Ireland Prison Service) were unaware of the threat of harm that Thomas posed. 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.**

1.4.25 **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.**

1.4.26 **Learning Point 6: There was limited understanding by professionals, and the public, of the dynamics and dangerousness of child to parent violence.**

1.4.27 **The impact of physical, psychological, emotional, and financial abuse of Ellen by her son is only too evident in the trauma that she experienced over an extended number of years. Thomas began abusing his mother as a young adolescent. There was limited understanding of this by professionals. This meant that Ellen did not receive the support that she required, and Thomas was not held accountable for his behaviour.**

1.4.28 **Through testimony provided in this review, and qualitative evidence provided by professionals, it is evident that society also struggles to understand and recognise domestic abuse in these circumstances. However, a new domestic abuse public awareness raising campaign was launched on 21st February 2022. This includes awareness raising on child to parent violence.**

1.4.29 **Action: Develop and implement a training programme on child (adolescent and adult) to parent violence to ensure that relevant frontline staff are sufficiently equipped with the right skills and knowledge to identify and respond to this form of domestic violence and abuse. This should also be extended to include their supervisors/managers.**

1.4.30 **In conclusion, this is a case that was dominated by systems and processes within and across organisations that had limited impact and resulted in a catalogue of missed opportunities. Effective systems and processes are needed to support professionals to continually learn, improve, and make better decisions.**

1.4.31 **In this regard, the DHR Panel are mindful of those professionals who worked with Ellen for many years, and those who continue to work with her family. The DHR Panel acknowledge the sadness they must be experiencing.**

1.4.32 **In terms of Ellen, this Review underscores the absolute critical need in Northern Ireland for a violence against women's and girls' strategy. This is one based on prevention, early intervention, supporting victims and survivors, education, and public awareness (At the time of writing this report, The Executive Office is currently undertaking a 'call for views' exercise to inform the development of such a strategy).**

1.4.33 **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 relationships (At the time of writing the Department of Health and the Department of Justice are undertaking a 'call for views' exercise to inform the next Domestic and Sexual Abuse Strategy for Northern Ireland), given the tenure of the current Strategy ends in 2023.**

1.4.34 **Finally, it is the DHR Panel's intention that the DHR findings and the implementation of identified actions will benefit victims of domestic violence and abuse and improve the health and well-being of our society.**

APPENDIX A

Overview Recommendations (8)

Agency	Recommendations
Rec. 1 **HSCT (x5)** **NIPS** **PBNI** **PPS** **PSNI**	**Undertake periodic assessment (every 5 years) of organisational culture relating to domestic violence and abuse, measuring:** • **Values and behaviours.** • **Standards, i.e., that policy, procedures, joint working arrangements, and training are in place and are working effectively in practice.** **The first assessment should take place as a matter of urgency, this year (2022)**
Rec. 2 **PPS** **PSNI**	**Ensure investigative and prosecution standards, as outlined in the PPS & PSNI Service Level Agreement:** • **Are subject to ongoing monitoring to ensure compliance,** • **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. 3 **SPPG** **PSNI** **(Joint Leads)** **HSCT(x5)**	**To provide an improved collaborative and co-ordinated response to safeguarding, the 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.** **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. 4 **EA**	**EA Child Protection Support Services (CPSS) will engage through its training programme for Designated Teachers, Governors, Schools, and EA staff, to facilitate learning on the importance of recording and sharing relevant child protection and safeguarding information. This will help inform staff about pupils who are living with domestic violence, enabling a more supportive response.**
Rec. 5 **DoJ**	**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:**

DoH	• **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. 6 **MARAC Operational Board** **ASSIST NI**	**The use of advocacy services to engage, and support victims pre, during, and post MARAC referral.** **The effectiveness of this engagement and support should be reviewed within 12 months from the publication of this DHR.**
Rec. 7 **NIPS (Lead)** **PBNI** **PSNI** **HSCT (5)**	**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. 8 **HSCT (x5)** **PBNI** **PSNI** **NIPS**	**Develop and implement a training programme on child (adolescent and adult) to parent violence to ensure that relevant frontline staff are sufficiently equipped with the right skills and knowledge to identify and respond to this form of domestic violence and abuse. This should also be extended to include their supervisors/managers.**

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 1 Rec. 1	Gateway Social Work Service Manager to review the decision making/actions in respect of cases where there are frequent referrals of Domestic Abuse Head of Service will lead a working group to: • Develop triggers within Gateway for escalation. • Develop a decision-making process around when an Initial Assessments should be progressed in relation to Domestic Violence. • Develop an audit schedule to review the escalation process.
HSCT 1 Rec. 2	Develop a joint action plan and accountability structure between Adult Mental Health and Children's Service to best practice within the Regional Think Family Strategy. The action plan will consider: • Improvement of a Mental Health Champions model. • Establish Domestic Violence Champions. • A joint Training programme to support champions and their mangers. • Guidance on Co-working domestic abuse cases between programmes of care. • Training on the impact of child to parent violence. • Think Family Social History tool. • Think Family Risk Assessment. • Further guidance around thresholds for convening multi-disciplinary meetings across programmes of care. • Guidance on an Escalation process around perpetrators of domestic violence.
HSCT 1 Rec. 3	Deliver a cross-divisional training programme on the impact and links between substance misuse and domestic violence.
HSCT 1 Rec. 4	The Head of Service will lead a working group to develop guidance will be developed to promote safe closures for individuals who are reluctant to engage.
HSCT 1 Rec. 5	Alert domiciliary care providers to their contractual responsibilities for reporting safeguarding concerns to Trust Named Workers. A learning alert will be issued detail each providers responsibilities and reporting mechanisms. The contract review agenda will be amended to include the learning alert.

HSCT 1 Rec. 6	**An accountability process will be developed to ensure decision-making is appropriate.** • **An audit schedule of Adult Protection referrals and closures will be implemented.** • **Dissemination of learning from this audit will be taken forward.**
HSCT 1 Rec. 7	**Develop an accountability framework for Trust MARAC work.** **Develop a process for joint working of MARAC cases to include an escalation pathway.**
HSCT 1 Rec. 8	**Develop a Trust-wide domestic violence strategy and action plan to provide effective professional and personal leadership in the delivery of desired outcomes by developing the domestic violence strategy and reporting on initiatives and outcomes with a focus on developing professional awareness of the impact of child to parent violence.**
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.**
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.**
EA Rec. 1	**EA Child Protection Support Services (CPSS) should support Schools and EA services with the right skills and knowledge to make timely disclosures of Domestic Abuse to Children's Social Work Services.**
EA Rec. 2	**The practice issues that have been identified in the Review will be presented to the EA's ESF. This will allow other partners within Education to facilitate learning in their own organisations.**
NIPS Rec. 1	**Working with partners, NIPS to develop and implement a procedure that will allow prison governors and licencing panels have all available information to help them inform their decisions when approving an address for either granting overnight temporary release or for release on licence. Cognizance is taken of those emergency situations when short notice is provided of the impending release.**

NIPS Rec. 2	**NIPS to review and update domestic violence training in Prisoner Development Units. This is to support staff in increasing their understanding around patterns of offending and escalating behaviour, including identifying when a referral might be made to PPANI on the grounds of current significant concern, even when the prisoner may be in prison for an unrelated offence.**
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 the 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 HSCT 2 Trust Unscheduled Care Child Protection questionnaire to ensure it includes consideration of wider family members.**
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,** • **Enhance the safeguarding of victims, and those at risk, through the appropriate sharing of information,** • **Contribute to wider management of risk of those who perpetrate violence and abuse.**