DOMESTIC HOMICIDE REVIEW

Executive Summary

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

ANTHONY

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

CHAIRPERSON'S FOREWORD

To protect their privacy, and safeguard their personal information, a pseudonym has been used throughout this report with the aim of protecting both the victim's identity and that of Shane who was arrested in relation to Anthony's death. There has been no trial or prosecution in this case.

On behalf of the Domestic Homicide Review Panel, and myself I would like to begin by extending my sincere sympathy to Anthony's family, his friends, and his community for their loss. During this Domestic Homicide Review, we have learned that Anthony was a much-loved Father, Uncle and Brother who was full of life, and is remembered with fondness and love. As a way of keeping Anthony at the forefront of our minds, photographs of him were shared with the DHR Panel members at Panel meetings.

As Independent Chair, I would like to put on record my thanks to Anthony's family and his friends for their involvement in the review process. I would also like to formally thank and acknowledge the work of all the Panel members, who brought their expertise and experience to each Panel meeting. I would also like to thank the Internal Learning Review authors, whose role is central to the review process and who worked hard to examine and understand how their agencies worked with Shane and with Anthony prior to his death.

The Domestic Homicide Review Panel and I recognise the profound shock and distress experienced by all those who knew Anthony, and this report endeavours to respectfully reflect his life and circumstances. It focuses on the specific timeframe established by the Terms of Reference (ToR) and is shaped by critical questions concerning how abuse against people with disabilities is addressed, how male victims are identified and supported, and how members of the Travelling community can be better assisted in accessing protection from domestic abuse. It is noted form the outset that here has been no prosecution in this case.

Jan Melia

Domestic Homicide Review Chairperson

2.0 **Terms of Reference**

2.1 This Domestic Homicide Review (DHR) was established following Anthony's death on **6th February 2022**. It was conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004. The DHR process focused on the period from February 2019 to February 2022. The Panel and Chair also considered significant and relevant incidents prior to this period, as appropriate. The purpose of the review was to:

- Review the way in which local professionals and organisations that came into contact with Anthony, worked individually and together to safeguard the victims.
- Review the way in which local professionals and organisations that came into contact with Shane, worked individually and together to tackle harmful behaviour and safeguard victims.
- Consider whether the victim was adversely impacted in the context of Covid-19 restrictions, with regard to provision and access to services and resources; 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.
- Ensure that there is a particular focus on all/any equality and diversity issues relevant to the victim accessing and engaging with services.
- Clearly identify 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.

2.2 Executive Summary

2.3 This Domestic Homicide Review (DHR) involves a familial homicide and considers agency involvement with Anthony and Shane. It examines the past to identify relevant background details before the homicide, whether support was accessed and whether there were any barriers to accessing support. The DHR takes a comprehensive approach with the aim of identifying appropriate solutions to make the future safer.

2.4 This Domestic Homicide Review deals with the circumstances surrounding the death of Anthony.

2.5 Anthony was a member of Northern Ireland's Traveller community, and the DHR process was conducted with this in mind.

2.6 Anthony had an acquired disability; he was an adult in need of protection and was at greater risk of abuse because of his disability.

2.7 Anthony was estranged from his ex-partner, and some of his children were in care. He was not considered as a carer for his children due to the extent of his disability. Social Services supported him to have ongoing supervised contact with his children.

2.8 Anthony was subject to physical, emotional, and financial abuse by some members of his family who regularly stole his money, medication, and items to sell. Family members often took his phone, leaving him with no means to ask for help from his carers/support staff.

2.9 Anthony reported some of the abuse against him to the PSNI with support from advocate social work staff and carers.

2.10 Anthony was the Applicant in seven Non-Molestation Orders (NMOs); NMOs were granted in respect of members of his extended family but not in respect of Shane.

2.11 Anthony was not identified as a high-risk victim of abuse and was not referred to a Multi-Agency Risk Assessment Conference (MARAC). This forum, made up of representatives from a range of agencies, develops plans for enhancing the safety of victims deemed at highest risk. Lack of any referral to MARAC was a missed opportunity. Anthony was a high-risk victim of abuse, and a MARAC referral could have improved multi-agency support.

2.12 Whilst there were no previous reports of abuse between Anthony and Shane, Anthony was at risk from other members of his family.

2.13 Shane was a member of the Traveller community in Northern Ireland. He was arrested and charged in relation to Anthony's death, but charges were dropped and there was no trial or prosecution in this case.

2.14 Shane was in receipt of several support services throughout the review period and was vulnerable because of his mental health.

2.15 Anthony was also known to services and was in receipt of support services for a prolonged period because of his acquired disability.

2.16 This DHR considers how those that worked with Anthony and his family individually and collaboratively and identifies lessons in relation to supporting and protecting victims with disabilities, male victims and victims who are members of Traveller communities in NI.

2.17 Although no prosecution has taken place in Anthony's case, the DHR remains a vital mechanism for learning and prevention. Statutory guidance affirms that criminal proceedings are not a prerequisite for conducting a DHR, and precedent exists in numerous cases where reviews proceeded without trial or conviction yet yielded critical insights into systemic failings and safeguarding gaps. This report follows that established approach, recognising that meaningful lessons can and must be drawn to improve future responses to domestic abuse.

3.0 **Engagement with Services**

3.1 Anthony was engaged with several statutory and voluntary services throughout the Review Timeline (2019- 2022) and prior to this period.

3.2 After he acquired his brain injury, Anthony used a wheelchair and became dependent on others for his care; he was assigned a care package and provided with a team of carers

supporting him in his home, with visits four times per day. Alongside carers, disability social workers supported Anthony, and he was assigned a community-based advocate.

3.3 Anthony had reported physical and emotional abuse by members of his extended family, and NMOs were granted on the following dates in the Review period:

- 6th February 2019
- 16th May 2019
- 4th March 2020
- 4th March 2020
- 23rd November 2020
- 23rd November 2020
- 4th May 2021.

4.0 **Key Findings**

4.1 As part of the review process information was sourced and collated from a range of organisations, departments, and witness testimonies. The information gathered forms the basis of this report and provides an overview of Anthony's lived experience. It tells us about who Anthony was and how he lived his life; it also tells us about his family and his culture. We know from the information gathered that Anthony was a family man who loved his children very much and lived for them. Anthony's life was characterised by intersecting issues that influenced him in complex and often contradictory ways. He was a Traveller, a man with an acquired disability who became a wheelchair user and a male victim of abuse.

4.2 **Key Finding 1: Domestic abuse can happen to anyone, and we must be aware of stereotyping and the potential for unconscious bias when working with victims. Training and awareness raising of domestic abuse that focuses on diverse groups of victims is essential.**

4.3 Several family members abused Anthony. The abuse was physical, financial, and emotional, yet he was not always seen as a victim of domestic abuse. Some of the abuse against him was normalised as part of the family/Traveller culture, some was not identified because he was a man, and some of the abuse was not reported because staff could not understand him or were unconvinced by his changing account of events.

4.4 Anthony did not always report his abuse, and he could be reluctant to report family members who were abusing him to Police and other agencies. Not reporting abuse is a key issue for all victims, and in this case, there were additional barriers to reporting because Anthony was a man, a Traveller and because he had a disability.

4.5 **Key Finding 2: Some services demonstrated a limited understanding of the dynamics and circumstances surrounding abuse where the victim is male. We need to continue to highlight abuse against male victims; raising awareness, improving access to MARAC, and increasing support for male victims.**

4.6 At times Anthony was not regarded as a victim because he was a male victim, and it appears that there was a lack of awareness about the nature of domestic abuse, and who can be a victim.

4.7 All victims of domestic abuse are vulnerable, both men and women. Whilst there are more women and girls impacted by domestic abuse, reporting of abuse against men and boys is increasing. In 2004/5 male victims accounted for 25% of abuse victims in NI, whilst in 2021/22 32% of abuse victims were men.

4.8 **Key Finding 3: There was at times a lack of understanding relating to Anthony's disability. We need to create a clear focus on the relationship between disability and abuse, examining risk, barriers and need, and working/training together to develop innovative practice.**

4.9 Anthony's disability and his abuse were inextricably linked and having a disability placed him at greater risk of abuse. He was an adult in need of protection. Despite this, there were times when Anthony's disability acted as a barrier in terms of reporting the abuse or accessing support.

4.10 Anthony could communicate his needs but could get frustrated communicating with strangers (those who were not his regular carers) and was known to sometimes throw things in his frustration. His movement and physical abilities could fluctuate, as could his ability to retain information/listen to what was being said etc.

4.11 Anthony would have benefited from more than one Independent Advocate, particularly in relation to his disability. The complexities of this case highlight the need to review how people with complex needs are advocated for, and how advocates are themselves supported.

4.12 **Key Finding 4: At times there was a lack of awareness of intrafamilial abuse. We need to develop a better understanding of this type of abuse, identifying all forms of abuse across the full range of family relationships.**

4.13 Anthony's abuse was not always recognised because of who perpetrated the abuse. It was intrafamilial and involved abuse by one or more members of his extended family. The relationship between Anthony and his abusers led to staff from some services discounting what was happening as abuse, despite NMOs being in place.

4.14 The review found Anthony to be a "high risk" victim of intrafamilial domestic abuse, but he was not identified as such. If Anthony had been identified as a high-risk victim at an early stage, this assessment could have resulted in him being referred to a MARAC meeting.

4.15 That there was no referral made to MARAC is a failing in this case. A referral into MARAC could have highlighted the abuse towards Anthony and would have enabled organisations working with him and his family to focus on the domestic abuse and act accordingly to affect an adequate and robust safeguarding response.

4.16 **Key Finding 5: At times, a limited understanding by professionals of the dynamics, circumstances and barriers relating to abuse in Traveller communities contributed to a lack of action in this case. There is a need to work together, to develop partnerships and practice that enable us to engage more effectively with Traveller Communities and families impacted by abuse in NI.**

4.17 Traveller communities can be culturally resistant to reporting issues to the police for fear of repercussions from within the Traveller community or because they have already experienced racism/discrimination from police or other services. Racism and inequality, and a lack of understanding of the cultural issues and barriers that often exist among professionals are all barriers to accessing mainstream services.

4.18 At times, behaviours exhibited by some family members appear to have been regarded as normal within the Traveller culture and it seems possible that some of the abuse against him was normalised as part of the family/Traveller culture. Services might not have intervened because of a fear of challenging cultural norms.

4.19 Anthony was a high-risk victim, and his life was characterised by abuse/trauma and intergenerational trauma. Yet he was regarded by some services as a troublemaker, as opposed to a victim. In terms of learning, a victim is a victim, and information shared by services should have highlighted the risk of abuse to Anthony, focusing on his vulnerability, and the fact that he needed adult safeguarding.

4.20 Anthony's case highlights that the way in which we support members of Travelling communities, requires time, understanding, a non-judgemental approach and trust building. It is important that this way of working is valued, well supported, and that organisations/departments can share information regarding this kind of approach.

4.21 Anthony's culture meant that at times, he was rendered invisible, as a victim of abuse; for example, when assumptions were made that the abuse was part of his culture. Paradoxically there were also times when his cultural difference was over-emphasised, for example, when it was assumed, he would not report abuse. These kinds of assumptions point to the need for training to increase awareness and develop understanding of unconscious bias.

4.22 We all need to be aware of our own unconscious bias when we work with victims, and we need to understand any preconceptions/ideas we might have about what constitutes a victim, or how a victim might behave. There is still a tendency for us to see victims in terms of stereotypes, i.e. that they are female, passive, poor, able-bodied etc. but domestic abuse can happen to anyone, and we need to challenge our own thinking in relation to this. As in

previous DHRs, Anthony's case demonstrates the need for professional curiosity and the need to challenge any unconscious bias we may hold.

4.23 **Key Finding 6: We need to continue to improve how we work together to support victims of domestic abuse, promoting multi-disciplinary approaches, organisational cultures, policies, processes, and information sharing protocols that enable us to better identify, support and engage with victims; with the aim of developing good practice that meets their diverse and changing needs.**

4.24 The work undertaken by frontline staff, Anthony's Disability Social Work Team (SEHSCT), his carers and his Advocate (CRJI) demonstrates good practice. Staff on the ground worked well together and developed a positive working relationship with him. There was extensive, direct contact over a substantial period, staff took time to develop the relationship and support Anthony building trust and changing how Anthony perceived/responded to what was happening, for example supporting him to apply for NMO's. It is important to ensure that the kind of approach they developed can be evaluated and replicated, and learning/information is shared across the various departments and organisations working with Traveller families.

4.25 Multi-agency working between the Trusts and other agencies was evidenced in this case and was of a good standard. There were times, however, when there was a lack of joined up working in respect of Anthony and all Services/Departments could have worked together more proactively; sharing information, planning together, and communicating with each other to gain a better understanding of what was happening with Anthony and some members of his family.

4.26 In reaching this finding, it is noted that the Multi Agency Support Hubs (MASH) were not in place at the time that this case took place, and that this would have offered Anthony a single point of entry for safeguarding, giving everyone a clearer picture of what was needed. It is vital that pertinent information is shared, and where there is an adult joint protocol in place, as was the case with Anthony, it should be underpinned by research about the person and the risks they face.

4.27 Anthony was recognised as an adult in need of protection, and several referrals were made under the Regional Adult Safeguarding Policy and Procedures in relation to the risks experienced by Anthony. That said, there were times the correct procedures were not followed, and relevant referrals were not completed. There were also occasions where

relevant information regarding the domestic abuse experienced by Anthony was not shared with adult safeguarding.

4.28 **Key Finding 7: The need for training in domestic abuse and completion of DASH for all appropriate housing staff. This work should be included in comprehensive domestic abuse training for all frontline staff and should commence before the end of 2024. The need to explore the potential of Housing Association staff availing of DASH training is also highlighted.**

4.29 NIHE do not currently refer cases to MARAC or complete DASH forms, and this is currently a gap in provision. Training on DASH completion and on domestic abuse is vital for frontline housing staff and this is a NIHE recommendation from an earlier DHR. This case also highlights the need for housing association staff to receive training on the DASH to better support victims of abuse.

4.30 **Key Finding 8: The need to continually improve risk assessments relating to abuse, focusing on the pattern of abuse/risk, and identifying how risks are impacting on the person/family. Connected to this there is a need to ensure that abuse risk assessments are linked to other assessments (e.g. health, disability, housing etc) the person may have, with the aim of developing a more complete picture of the person and their circumstances.**

4.31 Risk Assessments were undertaken and updated and the risk to Anthony from some members of his extended family was identified, with financial and physical abuse identified as the main risks, but there were missed opportunities to identify the ongoing pattern of abuse, and Anthony was not always asked about abuse, or referred to adult safeguarding.

4.32 There were several competing complexities of risk and need in the home where Anthony was staying when the violent incident that culminated in Anthony's death took place. There was however no evidence that these risks were assessed before/during his stay.

4.33 **Key Finding 9: The need to highlight and build upon good practice, sharing learning and developing evidence-based practice across departments, organisations and partnerships working with victims.**

4.34 Anthony's social worker from the PD team within SEHSCT developed a positive working relationship with him, through extensive, direct contact over a substantial period. The panel recognise this work and regard it as good practice. The time taken to develop the relationship and support Anthony was valuable, and there was a change in how Anthony perceived what was happening to him because of this work.

4.35 The work developed between PD social work and the CRJI advocate took time and highlights how trust with marginalised groups/individuals can be built over a sustained period of contact. The Panel recognises that this work formed the basis for Anthony's applications for NMOs and his decision to report abuse.

4.36 **Key Finding 10: The need to continually assess and improve management processes where there are multiple teams/agencies involved with families. Recognising complex, intersecting, or intergenerational issues and working together to establish more effective information sharing, risk assessment, risk management, communication and planning.**

4.37 On occasion, the RESWS team did not follow the correct Adult Safeguarding Policy and Procedure and did not complete the relevant referrals. RESWS did not share information regarding the domestic abuse experienced by Anthony to adult safeguarding; they did however liaise and share information with the SEHSCT.

4.38 The work by the multiple teams, agencies and Trusts involved with the family members, lacked co-ordination. There was no overarching management in this case and teams often worked in silos. The appointment of a case manager would have ensured better sharing of information, assessment, and management of all the risks in relation to the entire extended family. This would also have helped ensure involvement of the other Trusts and outside agencies e.g. PSNI, PBNI etc. who were also involved with the family.

4.39 Anthony's carers raised several concerns in relation to what was happening in Anthony's home and life and whilst some of these were raised with Safeguarding, there does not appear to have been a robust response on each occasion.

4.40 **Key Finding 11: The need to improve the use/completion of DASH risk assessments, ensuring that assessments are used confidently, that individual incidents are recorded as part of an ongoing pattern of abuse and all high- risk victims are referred to MARAC.**

4.41 Police failed to complete a DASH assessment with Anthony on twenty-three separate occasions and Anthony was not referred to the MARAC process. Failure to complete the DASH could be attributed to a lack of awareness of intrafamilial abuse and because of Anthony's communication issues. There were missed opportunities to address the abuse that was taking place.

4.42 Completion of DASH assessments should identify risk factors based on a broad assessment of risk, which allows for a review of the history of abuse. Assessments should also enable the pattern of abuse to be identified.

4.43 At times, police records were inconsistent, and this added to confusion about what was happening to Anthony and within the family. Officers did not always follow up or clarify with other agencies what was happening, and this meant the overall picture was unclear. Officers were sometimes unclear about any previous incidents or reports of abuse and were unaware that Anthony was known as a victim of domestic abuse.

4.44 **Key Finding 12: The transition process from Children to Adult Services should be reviewed and updated to ensure that it all processes are trauma informed, that information can be shared between agencies and that the young person who is moving from children's services to adult services is informed of what changes will occur and why.**

4.45 We found that Shane was not referred to Adult Mental Health Services when he left Child and Adolescent Mental Health Services (CAMHS) but was instead placed in the care of his GP.

4.46 There were gaps in information sharing from children to adult's services, and no clear understanding of Shane's mental health diagnosis. Whilst the Panel recognises that there was a process already in place for sharing information when moving from LAC to after care, there seems to have been a communication issue at the point of transfer.

4.47 **Key Finding 13: PBNI to work with the court service to address the timeliness of serving of summonses in respect of breach.**

4.48 A breach of a Probation Order (PO) condition was not dealt with, and Shane's summonses were returned unserved.

4.49 PBNI initially offered weekly contact, however due to a chaotic lifestyle the level of compliance was poor, resulting in the breach of his Probation Order.

4.50 **Key Finding 14: The need to continually improve the quality, accuracy, and timeliness of relevant child and adult safeguarding information, ensuring accurate recording, retention, referral, and information sharing with relevant partners.**

4.51 On occasion, the RESWS team did not follow the correct Adult Safeguarding Policy and Procedure and did not complete the relevant referrals. RESWS did not share information regarding the domestic abuse experienced by Anthony to adult safeguarding; they did however liaise and share information with the SEHSCT.

4.52 On two occasions, there is no referral documentation on record to suggest an adult safeguarding referral was made whilst Anthony was an inpatient. Adult safeguarding is included in the Mandatory Training for clinical staff and should be considered and escalated by the first person who suspects that an adult is at risk.

4.53 There was no referral made to MARAC, and it is the view of the Panel that this was a failing in this case. A referral into MARAC could have highlighted the concerning behaviour from various family members towards Anthony, and may have enabled organisations to make the link to domestic abuse and act accordingly to affect an adequate and robust safeguarding response.

4.54 **Key Finding 15: YJA to research and evaluate developments with their Youth Conferencing Model and provide/evaluate approaches that are more flexible to restorative justice for children with complex needs who engage in persistent offending.**

4.55 The Panel notes that during his time with YJA services Shane engages well and responds to programmes designed to address his offending behaviour.

4.56 The Panel notes that despite the many challenges in his life, Shane completed the requirements of all his youth conference plans.

5.0 Conclusions, Key Lessons & Overarching Actions

5.1 This review of the circumstances surrounding Anthony's death provides us with a unique opportunity to learn more about working with members of the Traveller community affected by abuse, about abuse where the victim is male, and about abuse where the victim has a disability.

5.2 Anthony's case highlights several issues relating to how we perceive victims and identify domestic abuse. One of the main findings in this case is the fact that Anthony was not regarded as a high-risk victim. In fact, there were times when Anthony was not even seen as a victim at all. The reasons for this were that he was a man from the Traveller community who had a disability, and because it was members of his extended family who perpetrated the abuse, as opposed to an intimate partner.

5.3 Anthony's life was quite extraordinary, and his case provides us with a unique learning opportunity to learn more about the barriers to services facing male victims, victims with a disability and victims from Traveller communities.

5.4 **<u>Learning Point 1:</u> More needs to be done to highlight all forms of abuse, with the aim of increasing our awareness and understanding about who perpetrates abuse, who can be a victim, and how we can best support victims to disclosure abuse.**

5.5 Anthony's case demonstrates the continued need for professional curiosity and the need to challenge any unconscious bias we may hold. We must keep asking ourselves questions about a family and it is dynamic, rather than taking for granted or making assumptions about what is happening. We must also be aware of our own unconscious bias when we work with victims, and we need to understand any preconceptions/ideas we might have about what constitutes a victim, or how a victim might behave.

5.6 **<u>Learning Point 2:</u> Anthony's case demonstrates the need for continued training and awareness of what constitutes abuse, to ensure that we do not fall into the "stereotype trap", where our own ideas about "victim" and "perpetrator" can influence and limit our response to abuse.**

5.7 Anthony had known domestic abuse for most of his life, and he was shaped by it. He could be difficult with staff or deny that anything was happening to him, but this did not mean he was not a victim. His story is full of trauma and reveals something of the nexus between trauma and abuse.

5.8 **<u>Learning Point 3:</u> Anthony's case provides us with an opportunity to review services/support for victims of intrafamial abuse and intergenerational abuse with the aim of promoting positive change.**

5.9 The frontline support work undertaken by CRJI, SEHSCT Social Work and the Care team was supportive and effective, and formed an important part Anthony's care. This work provides positive learning in this case. The long-term engagement with Anthony allowed him to build trust with staff and encouraged him to try to address the abuse through NMO applications. The type of work undertaken was multi-agency and victim focused, and this approach should be valued and replicable across services, as an aspect of good practice.

5.10 **<u>Learning Point 4:</u> The support Anthony needed had to be culturally aware and responsive and this work took time and commitment to achieve. Without support, Anthony, trapped by culture, disability, distrust of police and fear of the response, would not have sought help.**

5.11 The case revolves around equality and diversity issues, and Anthony's intersectional identity makers raised questions about disability, male victims, and race/culture within service delivery. Concerning advocacy around disability, the review has highlighted that Anthony would have benefitted from more than one advocate, a disability advocate could have enhanced his support.

5.12 The question of capacity was considered as part of this review, and whilst Anthony did have capacity, the assessments undertaken to determine this were narrowly focused. Assessments needed to be more robust and should have been updated as Anthony's circumstances changed and/or risk increased. Capacity Assessment could have been supported by additional advocacy in this case.

5.13 In relation to adult safeguarding, Anthony was not always referred to safeguarding and there were missed opportunities in several organisations. The agencies involved and the Panel have made recommendations concerning safeguarding processes and these should be implemented in the wake of this review.

5.14 The fact that Anthony was not referred to MARAC suggests the need for further training in relation to how we make referrals to the MARAC, and this should be reviewed as part of the overarching review of the MARAC in NI. Anthony was a high-risk male victim of domestic abuse, and we should learn from him. He was unlikely to report what was happening on his own and needed support and a trusting relationship with staff to identify and report what was happening to him.

5.15 Anthony's case highlights the need to increase and improve training/awareness in relation to the issue of domestic abuse in Traveller communities. We need a new training module to be developed that includes information about abuse against male as well as female Travellers, those with disabilities and the cultural aspects of abuse.

5.14 **Learning Point 5: Improving how we work together, internally and across organisations, to ensure better outcomes for victims of domestic violence involves the establishment of stronger, more effective multi-agency working, characterised by**

agreed protocols, effective communications, coordination and victim centred, trauma informed working practices.

5.15 In conclusion, Anthony's Traveller background, his disability, and the fact that he was a male victim, have each contributed to a lack of recognition of abuse, and a lack of action by some of the services working with him. It is important to note that the nature of the relationship between Anthony and his abuser/s also seems to have contributed to a lack of recognition.

5.16 Anthony needed support to recognise and accept that what was happening as abuse, and that he often did not want to report what was happening to him or who it was that was abusing him. This is not something that is restricted to Anthony, as victims of abuse often try to deny/minimise/disregard what is happening to them, and services should be cognisant of this.

5.17 The Panel and I would like to acknowledge the work undertaken by Anthony's carers, Social Work team and CRJ team who worked with him for many years. We are cognisant of the shock and distress that his death caused them and hope they avail of the support they need.

5.18 This Review underscores the critical need in Northern Ireland to continue to develop our work around domestic abuse. Working together to ensure prevention, early intervention, support, and education/awareness raising. A co-ordinated, multi-disciplinary approach will enable us to share learning, develop trauma informed work and better support victims.

5.19 It is the DHR Panel's intention that 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

REVIEW RECOMMENDATIONS

Overview Recommendations (13)

Agency	Recommendations
PSNI NIHE TRUSTS working together – collaborative training Rec.1	• Training for PSNI, NIHE, Social work and Health staff should include case studies highlighting domestic abuse against diverse groups of victims including women, men, people with disabilities and people from diverse cultural groups including Travellers. Domestic abuse definitions focusing on who victims are, and who can perpetrate DA should be highlighted in all training, with the aim of supporting staff to feel confident to identify and address abuse in all its forms. • Improved awareness of domestic abuse, who can be a victim and who can be a perpetrator. All types of abuse should be explained, and staff should be made aware of the need to recognise diverse victims. • Management teams in various organisations will progress collaborative working • Recommendation will be measured/monitored through training sessions delivered jointly and number of participants, plus feedback from participants
DOJ/DOH/PSNI/ Domestic abuse partnerships and various support agencies Rec.2	• All awareness raising campaigns should be developed with all victims and types of abuse in mind. We need to highlight abuse within different family relationships, and across a diverse range of victims. • Overarching campaigns need to have community-based element and engagement with diverse communities is encouraged • Improved awareness of domestic abuse, who can be a victim and who can be a perpetrator. All types of abuse should be explained, and staff should be made aware of the need to recognise diverse victims. Management teams and partnerships • Campaigns monitored along with the range of victims and relationships featured in DA campaigns – meeting to discuss community component of campaigns taken place – potential for partnership working to progress this.

DOJ/DOH – VICTIM'S COMMISSIONER MAP Rec.3	• Research to catalogue and map current services for male victims of domestic abuse should be undertaken and results, reviewed by government with a view to identifying gaps, increasing awareness, and improving service provision.
MARAC oversight group - Department of Justice. MARAC working group Rec.4	• The mechanisms by which male victims are referred to the MARAC should be improved as part of the overarching review of the MARAC in NI. Information about how to refer male victims should be clear, concise, well formulated and shared with all appropriate agencies. • There is potential for this work to fall under the remit of the Victim Commissioner's office, as the Office is has recently commenced research in relation to male victims. Initial research will focus on abuse against men in intimate relationships. There is scope however, for this research to extend overtime to include all male victims.
NIHE Rec.5	• The Panel recommends that training in domestic abuse and completion of DASH forms is rolled out for all appropriate NIHE staff and training for staff working in Housing Associations should also be considered. • NIHE have committed to DASH training, it is important that a wide range of frontline staff attends this training and training should include Housing Association staff. Training will increase risk awareness. NIHE training units delivered, and numbers of staff engaged in training. • Increased awareness of DA risk. • This work could be included in a comprehensive domestic abuse training package that is currently being developed for all frontline staff and due to commence before the end of 2024. The NIHE will engage with NIFHA (Northern Ireland Federation of Housing Associations) to explore the potential of Housing Association staff availing of DASH training. • Monitoring and measurement via No. of DASH forms completed by staff & number of victims supported.
DISABILITY ACTION & DOJ/DOH/SOF Rec.6	• Support and advocacy services for victims with disabilities in NI should be researched and reviewed with a view to identifying potential gaps, improving service provision, creating greater awareness of abuse of people with disabilities, supporting joined up thinking and allocating funding. Initial review information should be gathered from specialist agencies, such as Disability Action, who work directly with people with disabilities and often support victims of abuse as part of this work.

	• The Departments of Justice and Health should lead on this project, and there is potential for a research partnership with universities in NI. • Research is required to inform policy, budgets etc., in relation to the provision of DA support for people with disabilities. • Research should be conducted through a multi- agency task and finish group, led by Departments of Justice and Health should with terms of reference should be agreed. • Production of a single Research Report, documenting gaps in services, current issues, solutions, partnership working options produced and actions to progress work with disabled victims of abuse should be identified and agreed with partners involved.
SEHSCT & BHSCT + 3 Rec.7	• Review of current processes to ensure improvements in referrals, communications, and safeguarding. This recommendation is applicable to both the Belfast and South Eastern Trusts and learning should be shared with other Trusts to support positive change across all Trusts as required.
SEHSCT & BHSCT+ 3 Rec.8	• Where Social Work teams are considering the need to undertake a capacity assessment, they should be supported to do so by the specialist team (e.g. Brain Injury) involved with the client/patient. Contact should be made with the specialist team/department and information sharing, and a support agreement should be agreed.
TRAVELLERS H& W FORUM/ TRAVELLER THEMATIC GROUP / SOF Rec.9	• The Traveller's Health and Wellbeing Forum in conjunction with the Traveller Thematic Group and Traveller organisations in NI should work together to undertake a review of how organisations work together to support Travellers, identifying current gaps in provision and developing a plan of action for improving awareness, communication, and se • Challenging our unconscious bias toward those from Traveller communities and give recognition to the fact that Irish Travellers are one of the most marginalised and disadvantaged groups in Irish society. Improve our cultural awareness and address fears/expectations relating to work with Traveller communities. • As part of this work A training module could be co-produced with Traveller Communities for induction training for Police Officers, Social Services and other agencies and Community Groups, including Social Housing providers, mental health teams, Youth Groups, Counselling Services, and Statutory Organisations. This training module could focus on challenging our unconscious bias toward those from Traveller communities and give recognition to the fact that Irish Travellers are one of the most marginalised and disadvantaged groups in Irish society. This training module should

	include exercises to improve our culture awareness and address fears/expectations relating to work with Traveller communities.
SEHSCT & BHSCT +3 Rec.10	• The Belfast & Southeastern Trust should review current information sharing protocols and make necessary changes that ensure that accurate and up-to-date information is shared when a person moves to a new service, or another trust area. Learning should be shared with other Trusts to promote good practice. • Aim to improve adult safeguarding and disseminate learning across the trusts to develop an organisational response. • Meetings between Trusts actions monitored • Aim to increased/improve referrals and communications in relation to safeguarding adults.
SEHSCT & BHSCT+3 Rec.11	• Good practice ought to be recognised, and learning, including information about processes/outcomes should be shared across departments, services, and organisations, with the aim that others can replicate or use this learning to inform their work with abuse victims/survivors
SEHSCT & BHSCT+3 Rec.12	• The positive impacts of work with young people at risk need to be more accurately measured and recorded in greater detail to highlight good practice and link positive outcomes/impact and to therapeutic plans. Recognition and recording of positive work and its impact should be attached to therapeutic plans.
SEHSCT & BHSCT Rec.13	• The transition from LAC services to adult services should be reviewed and a trauma informed approach developed in which appropriate information is shared with adult services and the young person is kept informed of what is happening. For example, the transition to adult services and/or where a young person enters prison/remand or adult mental health services.

APPENDIX B

Agency Recommendations -PSNI (7)

*Please note recommendations in red are duplicate recommendations from previous ILRs

Lead	Recommendations
HOB PPB REC.1	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. Provision of appropriate training encompassing the timely use of Appropriate Adults and Registered Intermediaries Review of the Vulnerability Service Policy SP1816, and associated PSNI policies **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 - Head of Police College REC.2	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 - Identification of evidential opportunities and developing professional curiosity - Improving Safeguarding Measures for victims of domestic abuse - The importance of detailed, in-depth statements and interviews in domestic abuse investigations This will be achieved by: i. 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. ii. This should also include consideration of a standardised domestic and / or sexual abuse investigation guide / tactical menu / checklist for investigating officers.
PSNI - Head of Police College REC.3	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: - Identifying risk factors and broader assessment of risk - Professional judgement - Review of DV history - Requirement to refer non-offence, incident-only occurrences where the parties are high-risk MARAC back into MARAC, even if the DASH is standard or medium. - Identifying cases suitable for DVADS Power To Tell applications. - When a DASH is required in non-intimate partner and familial relationships This is to be achieved by: Review of current SOTP training by identified SME (subject matter expert) in the college and in conjunction with identified SPOC in PPB

	i. 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 deliver immediately accessible reference material. **This training should include specific attention on non-intimate, child-on-parent/adult relative domestic abuse.*
Lead for Safer Custody REC.4	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. Post-release risk assessment and identifying cases where the DP should be offered further visit with FMO.
PSNI – HOB PPB/MOB REC.5	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. This will be achieved by: i. Reviewing and improving MARAC referral forms and papers, for consistency and to reduce administrative tasks. 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. iii. Reviewing potential and appropriate actions for each partner agency; development of a key Action List for each partner iv. Standardisation and streamlining of all processes and procedures province wide. v. Emphasis on appropriate and adequate safeguarding of victims and management of perpetrators
HOB PPB REC.6	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 protection awareness, to include information on Child Protection Case Conferences and ACES training. Implementation of a compliance / audit mechanism to mandate swift information sharing at point of service. In occasions of non-domestic reports, an alternative technical solution to the PPN, to facilitate timely information sharing (alternative to Form 'O'). Dealing with children as victims, witnesses, and suspects Provision of appropriate training on the complexities of dealing with, and the difficulties experienced by Looked After Children Raising awareness of the risks and dispelling the myths associated with CSE and frequently Missing Children
PSNI – Head of Police College REC.7	Improving officer knowledge on the Traveller Community as a whole, with a view to improving the police response and effectiveness when dealing with members of the Traveller community. This will be achieved by adding the following specific topics into existing Hate Crime lessons: i. Highlighting the societal inequalities and oppression of the Traveller Community ii. Addressing the issue of mistrust of police in the Traveller Community

APPENDIX D

AGENCY RECOMMENDATIONS – PBNI (4)

Lead Officer or Agency	Recommendations
All Senior Managers REC.1	• PBNI will issue a reminder to all operational staff to ensure they liaise appropriately with both adult mental health and children's services where they are involved with the service user.
All Senior Managers REC.2	• Refresher Adult Safeguarding training to be delivered within PBNI
All PO's supported by Managers REC.3	• PBNI will engage with court service to address the timeliness of serving of summonses in respect of breach.
Senior Management Team REC.4	• PBNI to review internal diversity training to ensure that the needs of the Traveller community are recognised and responded to more effectively.

AGENCY RECOMMENDATIONS – YJA(1)

Lead	Recommendations
Director REC.1	• YJA will introduce a more holistic way of working with children with the most complex needs. • YJA will implement a new Enhanced Case Management model for working with children with the most complex needs. This model is trauma-informed and uses a case formulation and multi-agency approach.

APPENDIX E

AGENCY RECOMMENDATIONS

BELFAST TRUST (BHSCT) (24)

Lead	Recommendations
Director of MH and LD Rec.1	• Follow up after discharge from Home Treatment should be afforded the same priority as discharge from inpatient care. A target of three-day follow up should be set with maximum time lapse of seven days from date of discharge.
Director of MH and LD Rec.2	• First appointment after discharge from acute services should always be in person, unless assessed otherwise.
Director of MH and LD. Rec.3	• Mental Health services should have in place mechanisms to ensure locum medical staff have clear guidance around record keeping in particular contemporaneous notes.
Director of MH and LD Rec.4	• Mental Health services should put in place standards in relation to time frames in which outcome correspondence is processed to external stakeholders, for example, clinical letters. There should be mechanisms in place to monitor compliance and early identification of concerns.
Director of MH and LD Rec.5	• Mental Health services should examine caseloads and build capacity in the workforce of community mental health teams to provide a reliable level of outreach for patients that find it difficult to engage and to allow for some flexing up in intervention to prevent the requirement for acute mental health care.
Director of MH and LD Rec.6	• • The Mental Health service should put in place mechanisms for the formal assessment of the requirement for assertive outreach where there is frequent non-attendance.
Director of MH and	• The Mental Health service should put in place a framework to guide staff on actions to be taken where a patient frequently 'does not

LD Rec.7	attend.'
Director of MH and LD Rec.8	• The Mental Health service should review mechanisms for tracking new and live referrals. The service should review if it is necessary to inform the GP when an appointment is scheduled or the patient does not attend, this may avoid a re-referral.
Director of MH and LD Rec.9	• For patients transitioning from CAMHS, the Adult Mental Health service should agree frequency of contact when co- working during the transition period. The total contact from both teams should equate to no less than contact frequency before transition.
Director of MH and LD Rec.10	• The service should review standards for carrying out carers assessments. Where an assessment is not achievable within a time frame, the case records should indicate the rationale. Carers' assessments should offer at first assessment and reviewed thereafter six monthly.
Director of MH and LD Rec.11	• The IEAP guidelines should be adhered to in respect of waiting times. If this is going to be breached, then the service user should be risk assessed, and a decision made when they should be seen. This should be communicated to the service user and the referring agent.
Director of MH and LD Rec.12	• All attempts to review service users should be done directly with the service user. Practitioners should not rely solely on the account of a family member to establish mental state although this collateral view is important.
Director of MH and LD Rec.13	• A collateral history should be obtained by the key worker with all those professional agencies currently and previously involved with the service user
Director of MH and LD Rec.14	• A CRA should be completed on all service users in consultation with the service user, carer and other agencies/ professionals involved and should consider wider risks including that to • and from other family members. This should include the potential risk of domestic violence from the service user to others and the risk to the service from other family members in respect of domestic violence.
Director of Children's Services Rec.15	• The RESWS will review what level of training staff in RESWS require in relation to Adult Safeguarding.
Director of Children's Services Rec.16	• The RESWS should remind their staff of their responsibilities to complete an ASG referral when an ASG concern is raised.
Director of Children's Services Rec.17	• The RESWS staff should communicate ASG concerns with the services involved with the person alleged to have been harmed and the services involved with the person alleged to have caused harm to ensure effective communication, information sharing, and this will inform risk assessment and risk management.

Director of Children's Services Rec.18	• Community Children's services • The internal transfer process with CCS under 18-year-old social work teams to Leaving Care and aftercare services should be reviewed to agree what information should transfer with the young person and who should attend the transfer meeting.
Director of Children's Services Rec.19	• Adaptive Metallization Based Integrative Treatment (AMBIT) approach should be considered by CSS in collaboration with CAMHS and TSS service for LAC to help socially excluded young people with mental health difficulties and other co – occurring difficulties
Director of Children's Services Rec.20	• CCS should adhere to the statutory requirement to appoint a PA to a young person leaving care at the age of sixteen.
Director of Children's Services Rec.21	• Staff in LACAC should be provided with enhanced support to understand the role of adult mental health and drug support services.
Director of Children's Services Rec.22	• When there are multiple service users known to various teams, from the one extended family there should be a multi-agency meeting to include all the agencies, teams involved including other Trusts, PSNI, PBNI etc. Meetings will be used to obtain a holistic understanding of the family dynamics; level of contact; the potential risks between each service user to include the risks they potentially pose to others and the risks others potentially pose to them and to include Domestic abuse and vulnerability. This would ensure better sharing of information to inform identification of risk and thus inform risk assessment and risk management planning.
Director of Children's Services **Rec.23**	• For those young people over eighteen, where there are significant concerns regarding mental health and drug misuse there should be a review in relation to how to strengthen collaboration and the current interface working e.g. consideration should be given to a joint training champions model with regular interagency meetings.
Director of Unscheduled Care Rec,24	• Emergency Department Staff should be reminded of their responsibilities to make an Adult safeguarding referral by the first person alerted to a potential safeguarding concern.

AGENCY RECOMMENDATIONS

SOUTH EASTERN TRUST (SEHSCT)(4)

Lead	Recommendation
SET Adult Disability Services	• A risk management framework review will be undertaken within SET to ensure that people with acquired brain injury are included in PQC processes.

Rec.1	
Rec.2	• SET to consult with DV Lead Domestic Violence policy in relation to situations of concern for people with an Acquired Brain Injury
Rec.3	• SET Adult Disability will review their Communication and Information sharing across Agencies to ensure that it is effective.
Rec.4	• SET to consider Independent Advocate Options for people who have Acquired Brain Injuries and require support in relation to Domestic Violence.

AGENCY RECOMMENDATIONS

NIHE (1)

Lead	**Recommendation**
Senior Management Team	• There are challenges providing accommodation for members of the Travelling Community, particularly in relation to NIHE Transit Sites to accommodate their transient lifestyle. This relies on trust built up between the NIHE appointed Officer and the Travelling Community occupying the sites. In the course of researching NIH. E involvement in this case, it transpired that the contents of an email from this officer to another agency was relayed to the family, which resulted in a breakdown of trust and ill feeling. • It is important that all staff work to limit breaches and respond accordingly when a breach occurs. It is necessary for all staff to deal with information appropriately and follow policy guidance. • NIHE will work with all staff to reduce information breaches and increase awareness of policy and procedures relation to any information breaches that may occur.