DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY

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

Laura

Commissioned by the Domestic Homicide Review Senior Oversight Forum and written by **Independent Chairperson, Dr 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 the victim's identity. A family member chose the name Laura for her, and the alleged perpetrator has been given the name Michael.

On behalf of the Domestic Homicide Review Panel and myself, I would like to begin by extending my sincere sympathy to Laura's family, her friends, and her community for their loss. During this Domestic Homicide Review, we have learned that Laura was a much-loved mother, daughter, sister and friend.

As Independent Chair, I would like to put on record my thanks to Laura's family and friends for their involvement in the review process. I would also like to formally thank and acknowledge the work of all those involved in this review, including the Panel members and the Internal Learning Review authors, all of whom bought their expertise, and knowledge to the process.

The Domestic Homicide Review Panel and I are cognisant of the shock and distress felt by everyone who knew Laura and this report attempts to reflect her life. The report focuses on the timeframe established as part of the Terms of Reference (ToR) for Laura's case.

Dr Jan Melia
DHR Chairperson

1.0 Introduction

1.1 To protect Laura's privacy and safeguard her personal information, a pseudonym has been used throughout this report with the aim of protecting her identity. A family member chose the name "Laura." The name Michael was chosen for the alleged perpetrator during the review process.

1.2 The Domestic Homicide Review (DHR) for Laura involved a familial homicide and considered agency involvement with the victim and the alleged perpetrator. The review dealt with the circumstances surrounding the death of Laura.

2.0 Terms of Reference for the Review

2.1 The timeframe for the review was established at the first panel meeting on **December 14th, 2022,** by the review panel and agreed thereafter by the Strategic Oversight Forum (SOF). The review period commenced on **January 1st, 2018,** and ended on **September 11th, 2022**. As with all DHRs, information deemed relevant to our understanding of abuse in this case outside this timeline is included where required, and the report contains details of specific and relevant incidents prior to this period.

2.2 **Purpose of the Review**

- Review the way in which local professionals and organisations that came into contact with Laura worked individually and together to safeguard the victim.
- Review the way in which local professionals and organisations that came into contact with the alleged perpetrator, Michael, 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.
- 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.
- Highlight good practice.

3.0 **Contributors to the Review**

3.1 Contributions have been made to this review by members of Laura's family, PSNI, Health Trusts in NI, an independent Social Worker, an ex-partner of the alleged perpetrator and several of Laura's colleagues, friends and neighbours (PSNI information).

4.0 **DHR Executive Summary**

4.1 This Domestic Homicide Review (DHR) 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. This Domestic Homicide Review deals specifically with the circumstances surrounding Laura's death, who, it is understood, was murdered by her partner Michael.

4.2 Laura was a young woman and mother who always tried to help others, she had a caring nature and wanted a long-term relationship with a loving partner. She has been described as 'an amazing mummy.' Family and friends were aware that Laura had been the victim of domestic violence with a previous partner. Laura did not disclose this domestic abuse until after the relationship had ended.

4.3 When Laura contacted police to report issues with her ex-partner the response was limited, and the abuse she was experiencing was construed as civil in nature.

4.4 Laura had been advised that her ex-partner had been seen leaving her home and he had retained a key, indicating potential stalking and burglary.

4.5 During the review period, August 1st, 2018, to September 11th, 2022, police were involved with fifteen contacts/incidents involving Laura and Michael, however none of these reports related directly to domestic abuse incidents between Laura and Michael. Domestic abuse was reported by both Laura and Michael in relation to former partners. Laura had been a victim of domestic abuse by a former partner.

4.6 Laura and Michael had broken off their relationship more than once, and the panel received reports that Micheal coerced Laura and would use coercion including threats, constant texts and calls when Laura tried to leave the relationship.

4.7 Laura developed health related issues during her relationship with Michael. Laura's family have informed this review that she did not use recreational drugs.

4.8 Sexual violence is a feature of this case; the term includes a range of behaviours including sexual assault, sexually motivated assault or physical assault in the context of sexual jealousy.

4.9 This report is framed in the recognition that Michael, who is suspected of murdering Laura, took his own life whilst on High Court Bail. Michael's death means that the criminal case was not progressed.

4.10 It should be stressed that any mental health/alcohol related issues that Michael may have been experiencing do not excuse him from taking Laura's life, or perpetuating abuse against her.

4.11 This DHR considers how those that worked with Laura and Michael individually and collaboratively, seeking to identify opportunities for change and share good practice.

4.12 This review also identifies the lessons to be learned about domestic abuse and coercive control as a community/social issue in NI, examining how we raise awareness of all forms of abuse across the range of family relationships.

5.0 Key Findings

5.1 A detailed chronology of past events was collated from family members, organisational records and witness statements, and this enabled us to examine incidents relating to Laura and Michael. Laura's case highlights several issues, and our findings indicate that she was a caring mother, sister and daughter who was loved and cherished by those who knew her.

5.2 Laura had been a victim of abuse in a previous relationship. Repeat victimisation is strongly linked to higher risks of homicide in domestic abuse contexts. It can also lead to long-term mental health consequences such as PTSD, depression and anxiety. The fact that Laura had previously been in an abusive relationship would have increased her vulnerability, and it is likely that Michael exploited this.

5.3 Laura's case involves physical and sexual abuse and drug related harm, highlighting the issue of drug facilitated sexual abuse (DFSA) in intimate relationships.

5.4 Drug facilitated sexual abuse (DFSA) refers to situations where substances, often sedatives, alcohol, or psychoactive drugs, are used to impair a person's ability to resist or consent to sexual activity. These substances can be administered covertly or consumed voluntarily without awareness of their effects, leaving victims vulnerable due to diminished consciousness, memory loss, or physical incapacitation.

5.5 DFSA is particularly insidious because it often results in fragmented recollection, delayed reporting and challenges in gathering forensic evidence, making prosecution more difficult. The phenomenon raises critical concerns about consent, personal safety and the need for preventive strategies such as public education on drink-spiking risks and improved detection methods.

5.6 Victims may feel pressured or compelled to consume drugs under the guise of bonding or relaxation. Perpetrators may withhold prescribed medication, such as pain relief or psychiatric drugs, using denial of access as punishment or leverage.

5.7 The impact of DFSA on victims is profound. Survivors are likely to experience a complete loss of autonomy, feeling stripped of agency and unable to make decisions or resist abuse. They might face isolation from family or support networks as drug use leads to stigma or exclusion; perpetrators may exploit this, presenting victims as “addicts” to authorities, family, or courts, undermining their credibility and creating barriers when it comes to accessing support.

5.8 We cannot know for certain whether Michael coerced Laura into taking drugs on the night that she died, we also cannot tell if he used drugs on her without her knowledge. We do know however, that he was coercing Laura, and we know that he had used drugs coercively in a previous relationship. We also know that it was Michael, not Laura, who used drugs regularly.

5.9 Findings relating to how organisations engaged with Laura, and with Michael, are discussed in this section. The starting point is engagement with health services.

5.10 **Key Finding One: Professionals across health, social care and justice systems should be equipped to identify the coercive use of drugs including alcohol and prescribed medications in abuse cases, recognising that perpetrators may use drugs on victims, through forced consumption, manipulation and covert administration. Use of drugs to control victims should be considered as part of the coercive pattern of behaviour.**

5.10a This finding is important because it highlights a critical and often overlooked dimension of coercive control, where the misuse of drugs can be used as a tool to dominate, disorient, and silence victims. By equipping professionals across health, social care, and justice systems to recognise these patterns, practice can shift from viewing substance use solely as a lifestyle or dependency issue to understanding it as a potential indicator of abuse.

5.10b Improved awareness of DFSA would support more accurate risk assessments, better-informed safeguarding decisions, and more coordinated multi-agency responses. For victims, this change is significant: it increases the likelihood that their experiences will be believed, reduces the risk of misattribution or criminalisation, and enables earlier identification of harm, ultimately improving access to protection, appropriate support, and recovery pathways.

5.11 **Key Finding Two: The need to ensure that health professionals undertake appropriate systems checks at the point of referral and during initial assessments, asking questions about safety and domestic abuse risks, and completing/recording all details to enable appropriate decision-making/planning.**

5.12 Michael's attendance at the initial health assessment is a prime example of why this recommendation is needed. Following that assessment, the plan was to refer Michael for a psychiatric outpatient appointment, with no other input indicated or accepted at that time. However, the records show that, due to a failure in the assessment process, this onward referral did not take place. (To provide context, the Assessment Centre model was at an early stage of development at that time, and both practitioner-led and administrative processes were still being established).

5.12b Alongside this, some of the assessment notes relating to Michael are too brief, and the family profile section recorded that he was single with no dependents being noted. There was no reference to any relationships at the time of his assessment. The lack of information could have been because Michael was unwilling to share more information, or because of the way in which the record was completed.

5.13 Where Laura is concerned, when her baby was born the Trust completed an initial assessment in line with "Best practice guidance in pre-birth risk assessments in Belfast Health and Social Care Trust", however, the review of file records would indicate gaps in documentation and the review identified issues relating to recording of systems checks.

5.14 Belfast Trust has made their own recommendation relating to this, recognising that that gateway social workers should ensure that all multi-disciplinary and systems checks are completed and appropriately recorded on case records.

5.15 **Key Finding Three: The need to ensure that Family Health Assessments are commenced at the point of initial contact, that assessments are clearly documented at every contact and that Routine Enquiry is made, documented, and actioned (in line with Healthy Child Healthy Future Framework).**

5.16 In relation to this the Trust has also recommended that gateway social workers must ensure that all multi-disciplinary and systems checks are completed and appropriately recorded on case records.

5.17 Best practice guidance in pre-birth risk assessments in Belfast Health and Social Care Trust states that where professionals "identify risk factors in the pre-birth stage, they should immediately make an Understanding the Needs of Children in Northern Ireland (UNOCINI) referral, in writing, to the Gateway Team." In terms of the process, the Belfast Trust have identified areas that could be improved highlighting that

5.18 The record from Laura's pre-birth meeting in 2018 failed to indicate the need for/or presence of social work involvement with either Laura or her partner at the time. Even though a list of the computer systems checked was not recorded, there would be an expectation that this would be documented.

- There was no evidence of a G.P. check being completed for Laura or the baby's father. The G.P. did not receive any communications from Gateway regarding pre-birth risk assessment or domestic violence referral.

- No evidence of pre-birth liaison with Laura's Health Visitor, although a separate record of a supervision on 24/10/18 referenced this, as having been done.

5.19 We found issues in relation to information sharing between professionals supporting Laura when she was engaged with Health Visiting services in 2021. Information sharing between health visiting and other staff was not recorded, no antenatal contact appeared to have been made, and we could not find evidence of any information sharing or correspondence with any other professionals in Laura's case.

5.20 On a more positive note, Routine Enquiry (RE) was made at Laura's newborn review, with no disclosure of domestic violence or abuse. However, there is no record of further routine enquiry being made during Laura's 14-16 postnatal review, as recommended in the Healthy Child Healthy Future guidelines. The value of opportunistic routine enquiry is highlighted.

5.21 **Key Finding Four: The need for clear, accurate, and up-to-date record-keeping across all inter-agency correspondence, including follow-up documentation after Family Health assessments, ensuring that any changes, particularly in relationship status, are consistently recorded and communicated.**

5.22 Alongside findings relating to health services, this review highlights a number of issues relating to policing responses to domestic abuse, with completion of DASH forms noted as a particular concern.

5.23 There were seven separate occurrences with a domestic motivation during the review period, but only one of these incidents resulted in a DASH[1] form being completed; a total of six incidents should have resulted in a DASH being completed.

5.24 Call handlers did not appear to be cognisant of the type of incidents involved in domestic abuse or the risks associated with separation. Calls involving the possibility of abuse post-separation were not dealt with in a trauma-informed manner. Officers should be mindful of what victims are saying and must apply professional curiosity when individuals are reporting potential abuse.

[1] On November 9th, 2020, PSNI implemented the use of the Public Protection Notification (PPN), which is an information sharing document used to record safeguarding concerns which is shared with external partner agencies. This electronic system streamlines the process of risk assessment and management by improving the quality of Domestic Abuse, Stalking and Honour Based Violence (DASH) forms, enhancing the ability to identify and manage risk, and ensuring that referrals to support agencies are made swiftly and efficiently to provide a better overall service to victims. Prior to the PPN, DASH forms were discussed with the Duty Sergeant and risk agreed before being called into the Contact Management Support Unit (CMSU) for recording. The new process supports attending Police Officers as CMSU will run a risk calculator tool to assist in the risk assessment before sending to the Duty Sergeant to carry out a supervisor's review. Sergeants now have greater involvement in the risk assessment process and can utilise the DASH as a tool to aid investigative decision making and safeguarding actions. The Duty Sergeant's responsibility is immediate safeguarding and ensuring the correct referrals to partner agencies are made. PPN ensures accurate recording of information which is held electronically under the Niche occurrence.

5.25 Alongside this, the review also identified issues with DASH risk assessments in this case. One assessment graded as standard should, given what police knew about Laura's former partner, have been graded as medium.

5.26 When Laura contacted police again to report a possible stalking incident the call was not logged as domestic and no DASH risk assessment was completed.

5.27 Alongside this, we also found issues with completion of the DASH. There was only one DASH completed in this case. It contained insufficient detail about the risk that Laura was facing.

5.28 It is imperative that police complete the DASH assessment in detail because it provides a structured way to identify high-risk factors such as coercive control, stalking and threats, which may not be immediately obvious. A thorough assessment ensures accurate risk categorisation and can trigger multi-agency interventions like MARAC. A detailed DASH also creates a defensible record for decision-making. By capturing all relevant details, officers can better predict serious harm and safeguard victims effectively.

5.29 **Key Finding Five: The need to improve the knowledge of and competence in the undertaking and completion of the DASH risk assessment by PSNI officers, focusing on:**

- **Risk factors and broader assessment of risk**
- **Professional judgement**
- **Review of DV history.**

5.30 This case demonstrates the need for continued DASH training within PSNI. Officers must understand the importance of taking the time to complete a DASH with a victim of domestic abuse, even where the call for service itself appears relatively minor at the outset. DASH is designed to illicit further information from a victim about what is going on within the relationship, which then allows police officers to make an informed decision around the risk factors that are present, and to take steps to manage that risk. Where DASH is being completed, it is often the case that it contains either minimal information, or with all questions being answered 'no' if a victim does not wish to complete it.

5.31 Alongside issues relating to DASH assessments, this case highlights issues relating to referrals to Social Services. Of the fifteen incidents reviewed, four required a referral to Social Services, yet only one referral was made as reflected on Niche.

5.32 No welfare check was carried out on Laura or her child, and police did not have eyes on the child at any time. Northern Ireland implemented the Domestic Abuse and Civil Proceedings Act (Northern Ireland) (92021[2] in February 2022, introducing a legal framework that recognises domestic abuse as a distinct criminal offence. It recognises the impact that domestic abuse has on children with two child aggravators, one of which deals with children who are present during incidents of abuse, the other is where children are used in domestic abuse.

[2] Available at: https://www.legislation.gov.uk/nia/2021/2/enacted

5.33 Whilst this legislation was not in force at the time of this call, police officers should be aware of the impact of domestic abuse on children in terms of Adverse Childhood Experiences (ACEs), and as a matter of best practice a welfare check should have been conducted on both Laura's child and Laura in this case. The panel note that the PSNI are currently engaged with Women's Aid Federation Northern Ireland (WAFNI) to develop and deliver training specific to Section 8 and 9 linked to Child Aggravator.

5.34 **Key Finding Six: The need for services and professionals to continue to develop proactive information sharing, working together to protect victims and potential victims of abuse and ensuring appropriate correspondences, referrals, and planning.**

5.35 In relation to this, it is vital that police officers must ensure that appropriate referrals are completed in a robust manner and must contain all relevant information, including

- context of the call
- what has happened
- who the primary aggressor is
- what injuries have been sustained
- which children were present, and the location of those not present
- whether or not children heard/saw abuse occurring
- family dynamics

5.36 It is noted that the PSNI are currently reviewing Information Sharing Agreements and PPN protocols to establish if full risk assessments can be provided on Social Services referrals.

5.37 It is the view of the panel that police must identify and pursue all reasonable lines of enquiry in domestic abuse cases; this case should remind police of the need for professional curiosity as a key component of the investigation of domestic abuse cases. Securing these lines of enquiry at an early stage can assist police in pursuing a prosecution, even where a victim withdraws their cooperation.

5.38 Domestic abuse/coercive control is a patterned crime; it is never a one-off event. Building an accurate and detailed picture of a perpetrator's history is vital to ensuring the effective risk assessment of a victim, and risk management of a perpetrator to ensure behaviour does not escalate. Whilst the calls outlined in this case could be seen as 'low level,' without effectively investigating the circumstances and speaking with victims, it is impossible for police to establish with any deal of certainty exactly what has gone on**.** When evidential lines of enquiry are missed, so too are the opportunities to safeguard victims and risk manage perpetrators as a result. Domestic motivated calls for help/service must be elevated, and all potential lines of enquiry exhausted before occurrences are closed.

5.39 This case also highlights the importance of police officers pursuing evidence-led prosecutions in respect of domestic abuse, as opposed to being heavily reliant on victim engagement to successfully

prosecute cases. The gathering of 999 call recordings and the use of Body Worn Video and photographs to document injuries should be a priority and routine line of enquiry for police to follow up in all domestic abuse cases. The Northern Ireland Court of Appeal has determined that even if a victim withdraws their complaint, the public interest may still require a prosecution,[3] and the case of Gerard McGuinness v The Public Prosecution Service (PPS) for Northern Ireland (2017) NICA 30 establishes precedent for admitting BWV footage as hearsay evidence.

5.40 **Key Finding Seven: The need to continue to improve the quality / standard of domestic and / or sexual abuse investigations, identifying and pursuing all lines of enquiry, and ensuring a trauma-informed approach.**

5.41 Out of the fifteen occurrences examined by the PSNI ILR reviewer, five raised concerns relating to Michael's mental health. The first record that mentions Michael's mental health issues was made on January 1st, 2018, following a report to police that Michael had sent a text to his partner stating he was going to kill himself. It was further noted on this occurrence that Michael had previously attempted to end his life and was likely under the influence of drugs. No further details were logged in relation to this disclosure, and no flag was placed on Michael's Niche nominal to reflect this.

5.42 Michael's mental health was not considered during some of his interactions with police. PSNI held information on his mental health that was not checked by anyone prior to attending calls involving Michael. This was not helped by the fact that flags had not been utilised to easily to inform other officers of Michael's history.

5.43 There is no current policy in place for police in relation to referrals or signposting to Support Services for those who present with such issues that come into contact with police. Police can make use of Article 130 of the Mental Health (Northern Ireland) Order 1986; however, this only applies to persons found in a public place. There are also additional provisions within the Mental Health (Northern Ireland) Order 1986 that allow for a warrant to be obtained that allows police to remove a person to a place of safety. This, however, requires authority from the courts and can be time consuming.

13.44 **Key Finding Eight: The need to address the fact that there is no current policy relating to referrals/signposting to support services for those with MH issues that come in contact with police (this issue has been identified in previous DHRs)**

5.45 This will require increased collaborative work 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 partner organisations.

5.46 The need to work with victims/families using a professionally curious approach is recognised and recommended in this case. Records for this case make no reference to checking weight loss, stress,

[3] Gerard McGuinness v The Public Prosecution Service (PPS) for Northern Ireland (2017) NICA 30.

flaky scalp, all of which could indicate how stressed Laura was in her relationship. We could not determine if the question of stress was discussed with Laura when she contacted her General Practitioner.

5.47 Professional curiosity should always be a key component of the investigation of domestic abuse cases; with the right kind of rapport, victims will often disclose a wealth of information with regards to the history of the relationship on initial response by police. Securing these lines of enquiry at an early stage can assist police in pursuing a prosecution, even where a victim withdraws their cooperation.

13.48 **Key Finding Nine: The need for all staff from any agency working with victims and potential victims of domestic abuse, to be professionally curious in all aspects of their work, including when dealing with health assessments, police interviews, DASH forms, calls, referrals etc.**

13.49 This key finding is applicable to all cases involving domestic and sexual abuse, and it is important that services continue to develop professionally curious approaches when working with victims and survivors.

13.50 Relative to this the question of previous domestic abuse must be considered at initial stages of engagement with victims and survivors.

13.51 The fact that Laura had been a victim of abuse in a previous relationship is a key aspect of this case. We know repeat victimisation is strongly linked to higher risks of domestic homicide; we also know that coercive control is a key indicator for domestic homicide.

13.52 Whilst Laura did not report abuse in her relationship with Michael, she did contact police about her ex-partner during the relationship with Michael. This suggests that she was fearful and at risk. The limited response from police highlights the need for agencies to do more to recognise abuse, trauma and heightened vulnerability.

. 13.52a Experiencing more than one abusive relationship can indicate underlying risk factors such as low social support, financial dependence, prior trauma or patterns of coercive control that make recovery harder. Victims may also have diminished trust in services due to repeated negative experiences, making engagement more challenging.

13.53 The only appropriate response to victims like Laura is for agencies to adopt a trauma-informed, non-judgmental approach, avoiding questions that imply blame and focusing on understanding the victim's circumstances and resilience factors. Interventions should include long-term support not just crisis response, such as counselling for trauma recovery, empowerment programmes, and practical assistance with housing and finances. Multi-agency collaboration is crucial: health, social care and justice services should share information and coordinate safety planning. Recognising the complexity of repeat victimisation should help agencies tailor responses that build trust, address root causes and reduce the risk of future abuse.

13.54 **Key Finding Ten: Agencies must be equipped to recognise the complexity of repeat victimisation, developing responses that build trust, address root causes, and reduce the risk of future abuse.**

6.0 Conclusions, Key lessons, and Overarching actions

6.1 The purpose of DHRs is to identify lessons, and the starting point for all reviews is to ask how we can learn from what happened to help prevent and address domestic abuse. In this case, the learning is about how we engage with victims/potential victims of abuse; how we listen to, record, and share their experience of abuse, ensuring effective communication with one another as professionals, and with victims and their families. Mental health is another area for learning in this case.

6.2 **Key Learning Point 1: Laura's case highlights sexual violence as part of the continuum of violence against women, and as a component of domestic abuse and coercive control within intimate and familial relationships. Her case highlights sexual violence as a pervasive crime that is often hidden, under-reported or misunderstood.**

6.3 Healthy relationship work is acknowledged as one of the main vehicles for highlighting sexual violence as a form of abuse within intimate relationships, and the panel recognises the work undertaken by a range of organisations in Youth Groups, Schools and with professionals. The panel expresses the need to ensure that this work continues.

6.4 We know that when an intimate partner perpetrates sexual violence it leads to very poor outcomes, with studies showing associations between IPSV (Intimate Partner Sexual Violence), posttraumatic stress disorder (PTSD), anxiety, depression, fear, shame, hyperarousal and suicidal ideation. Victims report being damaged to the core of their being, reporting intense struggles with self-esteem and body image, self-loathing and a lack of confidence. Victims can also feel deprived of agency, autonomy and personhood, dehumanised, and feel like an object to be used and discarded. Reporting sexual abuse within the relationship can be particularly traumatic, and it may take time for victims to tell professionals what has happened.

6.5 For Laura, reporting sexual abuse would have been very difficult. Laura had been a previous victim of abuse and did not discuss issues relating to abuse in her earlier relationship until after that

relationship had ended. When Laura did contact the police for support following issues post separation, the response was limited and this would have impacted negatively on Laura.

6.6 All staff working with victims of IPSV should be aware of the devastating impact on victims, working to develop a trauma-informed rapport built on empathy and understanding. Staff need to ensure that the questions asked of victims are supportive; questions should aim to encourage disclosure. Victims may need an Advocate, they may need more than one conversation and they may need time. Disclosure can often be a process rather than a single moment. When victims feel they are being supported/safe they are more likely to disclose, more likely to engage, and more likely to participate in prosecution processes.

6.7 **Learning point 2: The use of DFSA (drug-facilitated sexual abuse) is highlighted in this case, where substances may be used, either covertly or through coercion, to impair an individual's capacity to give informed consent, or recall events. This case underscores that DFSA does not solely occur in isolated or stranger-perpetrated incidents but can an integral part of coercive control within relationships, where coercive/covert use of drugs forms part of a broader pattern of abuse.**

6.8 Laura's death highlights the need for professionals to recognise the indicators of DFSA, including unexplained intoxication, inconsistencies in memory, or patterns of vulnerability linked to substance use, and to actively consider how drugs, coercive control, and sexual abuse may intersect.

6.9 In the context of coercive control, DFSA needs to be understood not as an isolated incident but as part of a wider pattern of domination, where substances are used to undermine autonomy, impair resistance, and facilitate ongoing abuse. Perpetrators may use alcohol or drugs strategically, through pressure, manipulation, or exploitation, to increase dependency and reduce a victim's capacity to challenge or leave the relationship. This aligns with research on "chemical control," which highlights how substances can be used alongside other controlling behaviours to restrict freedom and reinforce power imbalance. Within this dynamic, the boundaries between consent, capacity, and coercion become increasingly blurred, making it more difficult for victims to recognise abuse and for professionals to identify it. Recognising DFSA within the framework of coercive control is critical to ensuring that patterns of abuse are not minimised or missed, and that responses move beyond incident-based thinking to a more holistic understanding of risk and harm.

6.10 **Learning point 3: Children are victims in domestic abuse, and they can also be witnesses; agencies need to recognise and take appropriate action to recognise, protect and support children that have experienced domestic abuse.**

6.11 There were a total of fifteen incidents reviewed involving Laura and/or Michael. Four of the fifteen incidents required a referral to Social Services, but only one such referral was made.

6.12 Laura's child was not linked to three of these occurrences, and the risk to the child from domestic abuse was not recognised. We must all be cognisant that a missed referral to Social Services increases risk to children, and this should be a consideration in all domestic abuse cases.

6.13 **Learning Point 4: Michael's mental health was not always considered during his interactions with police, and whilst police held information about his mental health, this was not checked by anyone prior to attending calls involving Michael. All officers attending incidents involving Michael should have accessed the information/flags about his history/behaviour available to them.**

6.14 The mental health issues in this case warrant further action/consideration and whilst, as noted, there is no current policy in place for police in relation to referrals for those presenting with mental health issues, this case highlights the need to:

(1) Review the need for such a policy

(2) Recognise the importance of logging information in relation to mental health on police systems, officers should be aware of support options for those suffering with such issues, and the need for sign-posting people to relevant support services.

6.15 **Learning Point 4: Michael took his own life whilst on High Court Bail, indicating the need to review bail conditions. Police and prosecutors should rigorously assess bail conditions when releasing an accused pending trial, to ensure the safety of both the individual and the wider public. This finding has been made in previous DHR reports.**

APPENDIX A.

OVERVIEW RECOMMENDATIONS

PANEL RECOMMENDATIONS (5)

Agency	Recommendation
PSNI, Health Trusts Rec.1	• Strengthen Professional Recognition of Drug-Related Coercive Control • Ensure that existing domestic abuse, safeguarding, trauma-informed practice, and coercive control training programmes explicitly include content on the coercive use of alcohol, illicit drugs, and prescribed medications, where this is not already covered. Training should raise awareness of how perpetrators may use substances through forced consumption, manipulation of medication, withholding treatment, or covert administration as part of a wider pattern of coercive and controlling behaviour. • Increased awareness and recognition of the coercive use of substances within abusive relationships, resulting in earlier intervention, improved safeguarding, and more effective support for victims across health, social care, and justice systems. • Training content should be reviewed and updated within 6 months, • Ensure that 90% of frontline practitioners complete the training and that all relevant agencies incorporate drug-related coercive control indicators into risk assessment and referral processes. Monitor increases in the identification and recording of such cases through annual audits.
PSNI Rec.2	• Police should address the lack of any current policy in relation to mental health referrals or signposting. A new policy should be devised. • Increased support for those with MH issues who are arrested/detained and increased support for victims of abuse who report issues with MH during investigation by police • Signposting options clear to officers and information given to those in need
PSNI Rec.3	• Police and prosecutors should rigorously assess bail conditions when releasing an accused pending trial, to ensure the safety of both the individual and the wider public. • Improved accountability of alleged perpetrators • Improvements in protection for victims etc. • Bail arrangements monitored and recorded to ensure compliance and information used to inform risk assessments as appropriate.

Mental Health Assessment Centre SEHSCT Rec.4	• The Mental Health assessment centre must ensure that all onward referrals to appropriate professionals are completed and embedded into practice. Referrals must be actioned within 2 weeks of assessment. Ensure onward referral process is robust and effective
PSNI Rec.5	• Deliver and evaluate appropriate education for police in relation to sexual assault with the aim of improving awareness of impact of sexual abuse in relationships and improving sign posting and referrals for victims to relevant support services, in particular mental health services. This will be achieved by: • Implementation, as required, of a referral mechanism to relevant support services and provision of relevant support service literature to frontline officers. • Increase awareness of sexual violence in domestic abuse cases, improve access to support for victims, increase awareness, and opportunities for disclosure of SV

AGENCY RECOMMENDATIONS

BHSCT(5)

Agency - BHSCT	**Recommendations**
CCS Director Rec.1	• Gateway social worker should ensure that systems checks, and multi-disciplinary liaison where applicable, are completed and recorded on case records to enable appropriate decisions to be made about next steps, at the point of referral and within the course of the initial assessment. • Evidence of a comprehensive multi-disciplinary liaison and systems checks have occurred as part of duty screening processes, and initial assessment to ensure effective communication across professional groups, and appropriate decision making • Previous Learning from CMR / DHR has been shared within the Trust Gateway Services in October 2021 and February 2022 regarding the need for completion of systems checks to inform decisions taken in respect of referrals at the point of screening. The duty sheet which is completed in respect of each new referral was amended in March 2022 to enforce this practice point, and an audit completed in November 2022 provided assurance that the learning was being implemented. A review audit is planned for October 2023. • Learning from this ILR will be shared with the teams, and the planned audit will be extended to include completion of multidisciplinary checks during the initial assessment.

CCS Director Rec.2	• Health Visitors should ensure that the Family Health Assessment is commenced at the initial contact, is clearly documented and updated following every contact and that Routine Enquiry is asked, documented, and actioned in line with their Healthy Child Healthy Future visits. • Evidence of a comprehensive Family Health Assessment by the Health Visitor, commenced at the initial contact, and updated following subsequent visits. • Within the Family Health Assessment there is evidence that Routine Enquiry has been discussed by the Health Visitor, stating if a disclosure has been made or not. • Evidence within Health Visiting records indicating actions taken upon disclosure of domestic abuse.
CCS Director Rec.3	• Health Visitors should ensure that all correspondence between agencies, emails and discussions are clearly recorded within the Child Health Record and PARIS electronic system. • The importance of record keeping, ensuring that all correspondence emails and discussions are documented, will be highlighted to all Health Visitors. • Evidence of all correspondence emails and discussions are clearly recorded within the Child Health Record and PARIS electronic system. • Assistant Service Manager for Health Visiting to Audit electronic records and Child Health records • Safeguarding Children Nurse Specialists to highlight this recommendation at Health Visiting team meetings and during supervision.
Director for Mental Health Rec.4	• Mental Health assessment centre must gain assurance the processes are implemented to ensure completion of onward referrals to appropriate professionals and embedded into practice. Further these must be actioned within 2 weeks of assessment. • All service users assessed as requiring an onward professional referral will have this completed in a timely manner. • Audit of mental health assessment centre records
Director of Maternity, dental, gynae and sexual health. Rec.5	• GUM services will increase completion of the Are you safe? section of the assessment form • Are you safe? question will be completed for service users attending the clinics - audits completed on a monthly basis to measure compliance.

APPENDIX B

AGENCY RECOMMENDATIONS

PSNI (4)

Agency - PSNI	Recommendation
PSNI - Head of Police College 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. - Professional judgement - Review of DV history This is to be achieved by: i. Review of current SOTP training by identified SME (subject matter expert) in the college and in conjunction with identified SPOC in PPU. ii. Review of ICIDP input on domestic abuse iii. 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 attention on domestic motivated civil disputes that potentially may amount to the DA offence*
HOB PPB Rec.2	To increase the protection and support provided to: Children in need of protection (should this be at risk of harm as opposed to in need of protection? Not sure?) 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 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').
Police College Rec.3	To increase the welfare and support for persons in contact with police officers suffering mental health crisis.This will involve awareness raising around the signposting or referring of persons to relevant support services, in particular mental health services. This will be achieved by: Implementation, as required, of a referral mechanism to relevant support services. Provision of relevant support service literature to frontline officers
PSNI - Head of Police College Rec.4	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: 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.