DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY

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

Marta

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

Chairperson's Foreword

On behalf of the Domestic Homicide Review Panel and myself, I would like to begin by extending my sincere sympathy to Marta's family, her friends, and her community for their loss. During this Domestic Homicide Review, we have learned that Marta was much-loved, always willing to help others, she loved spending time with her child, and had lots of plans for their futures.

As Independent Chair, I would like to put on record my thanks to Marta's family and 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 author, whose role is central to the review process and who worked hard to examine and understand how their agencies worked with the alleged perpetrator (AP).

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

Dr Jan Melia
DHR Chairperson

1.0 Introduction

1.1 To protect Marta'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 "Marta," and they also chose the name Patrick for the alleged perpetrator.

1.2 The Domestic Homicide Review (DHR) for Marta 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 Marta.

2.0 Terms of Reference for the Review

2.1 The timeframe for the review was established on July 27th, 2023, by the review panel and agreed thereafter by the Strategic Oversight Forum (SOF). The DHR process focused on the period March 2021, to March 2023.

2.2 Purpose of the Review

- Review the way in which local professionals and organisations that came into contact with Marta, 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 (AP), worked individually, and together, to tackle harmful behaviour and safeguard victims.
- Review the way in which local professionals and organisations that came into contact with Marta's child, worked individually and together, to safeguard the victim.
- Review the circumstances/processes and policies relating to the Patrick's release from prison, and how he came to live at Marta's home.
- 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, consider whether there were barriers to accessing to services because of language/translation problems 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 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.

3.0 **Contributors to the Review**

3.1 Contributions have been made to the review process by Marta's family, and the PSNI. Additional information was gathered through conversations between the Chair and Marta's place of work and with the schools attended by Marta's child. Discussions with migrant organisations and women's groups have also taken place and information gathered at these meetings has been included in the report in the background section and has informed discussion and analysis at panel meetings.

4.0 **DHR Executive Summary**

4.1 This Domestic Homicide Review (DHR) examines past events 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 holistic approach with the aim of identifying appropriate solutions to make the future safer. This Domestic Homicide Review deals specifically with the circumstances surrounding the death of Marta, who was murdered by Patrick.

4.1.2 Marta was a devoted mother, daughter and sister who worked hard to provide stability for her child. Having secured permanent employment, she had achieved a

degree of financial security and was making plans for her and her child's future. She maintained close relationships with family and friends and was regarded as a source of support to those around her.

4.1.3 Following Patrick's release on bail, Marta provided him with accommodation in the hope that he could stabilise his circumstances and move forward positively. At the time he moved into Marta's home, Patrick had already been abusive towards several family members; however, there had been no reports of abuse towards Marta or her child. Despite Patrick's established pattern of abusive behaviour, his move into Marta's home did not trigger a coordinated assessment of risk, nor was there evidence of targeted intervention or support to address his behaviour. Consequently, an opportunity to reassess and manage the risks arising from these changed circumstances was missed.

4.1.4 In October 2025 Patrick pleaded guilty to Marta's murder, aggravated by domestic abuse; he also pled guilty to (2) Arson with intent to endanger the life of Marta's child; (3) Arson being reckless as to endangerment of the lives of those living in the adjoining terraced houses; (4) Theft of Martha's Bank card (13th October 2025).

4.2 The report notes that Patrick may have been experiencing mental health difficulties and that he disclosed a history of childhood abuse. Whilst these issues are acknowledged, they do not excuse, justify, or mitigate responsibility for the killing of his sister or the abuse perpetrated against other members of his family.

4.2.1 Patrick could have killed Marta's child when he set fire to Marta's home.

4.2.2 Patrick had no recognised permanent address.

4.2.3 There were no reported incidents of abuse relating to Marta; however, Patrick had been reported to police by family members prior to him killing Marta.

4.2.4 Family members raised concerns about Patrick's behaviour in 2021, and Patrick was abusive towards several family members.

4.2.5 Patrick's bail conditions focused on his abuse towards his mother however the risk he posed towards Marta, and her child was not assessed.

4.2.6 This DHR considers how those that worked with Marta and Patrick, individually and collaboratively, seeking to identify opportunities for change and share good practice.

4.2.7 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. This enabled us to identify incidents relating to Marta or Patrick.

5.2 Key Finding 1:

The need to improve engagement with migrant communities/families impacted by abuse, working from a community -based approach to promote relevant information about abuse, increase awareness about support services, and outline what happens when families report abuse.

5.2.1 The fact that Marta did not seek help, potentially due to fear, highlights the need for proactive engagement with migrant communities to increase awareness of abuse, coercive control, legal rights, available support services, and what individuals can expect when reporting abuse to the police or accessing support.

5.2.2 Language barriers were evident in this case. While interpretation services, including The Big Word, were used effectively on some occasions, however there were instances where such services were unavailable or staff did not use them. Issues identified related to telephone connectivity and inconsistent use of interpretation services by professionals.

5.3 **Key Finding 2:**

Where an alleged perpetrator has a history of domestic abuse, there is a need to assess the risk to those living at the potential bail address, establish and maintain contact with addressee and ensure the alleged perpetrator is effectively monitored and signposted to relevant agencies.

5.3.1 There was an ongoing risk to Marta and her child from the time Patrick came to live with them. Although periods of stability were evident, the risk of further violence from Patrick was ever present, his abusive behaviour had never been addressed. Following the provision of a bail address, Marta was effectively left to manage the situation alone, which should not have been the case.

5.3.2 In relation to the risk posed by Patrick, the PSNI objected to bail and provided the court with bail objections, however the decision was made to release him on High Court Bail and after some time Marta contacted police to provide a bail address.

5.3.3 Information provided to the High Court in relation to Patrick's bail application did not fully reflect his history of domestic abuse and associated risks across all family members.

5.3.4 There was no evidence found that a risk assessment relating to bail was carried out in respect of Marta and her child, in conjunction Patrick’s known domestic history, alcohol misuse and/or health issues.

5.3.5 Police systems were not updated to reflect that Patrick was residing with Marta.

5.3.6 Bail checks should have taken place and information relating to the bail address should have been updated in a timely manner.

5.4 **Key Finding 3:**

As a practical tool for measuring risk, each DASH assessment should be considered as part of the pattern of abusive behaviour, and assessments should be used to consider the full extent of risk to the victim, but also to other family members.

5.4.1 DASH risk assessments were routinely completed with minimal information. In cases where positive responses were identified, there was a consistent failure to record sufficient supporting detail, including the timing, context, and circumstances of reported incidents. This significantly undermined the assessment of risk and the rationale for subsequent decision-making.

5.4.2 Officers failed to recognise high-risk factors and did not fully understand the risks posed by Patrick or take sufficient measures to implement appropriate safeguarding.

5.4.3 Completion of DASH risk assessments in this case tended to focus on a particular incident and this meant that the pattern of abuse and the risk posed by Patrick was not fully understood.

5.4.4 DASH forms completed by PSNI indicate that officers did not consistently review the history between the victim and perpetrator when undertaking risk assessments. Instead, assessments relied heavily on information disclosed at the point of reporting, rather than being informed by the wider pattern of offending and previous incidents known to police.

5.4.5 The failure to routinely consider and incorporate relevant historical information meant that incidents and disclosures recorded within DASH assessments were not always understood within the context of cumulative and escalating abuse. Consequently, indicators of increasing risk and escalation in Patrick's behaviour were not consistently identified, recorded, or reflected in the assessment of risk.

5.4.6 In relation to some of the incidents of abuse against Patrick's mother, there was no information recorded to suggest that she was deemed to be an Adult at Risk of Harm and no further safeguarding actions were noted in some incidents.

5.5 **Key Finding 4:**

Accurately and timely recording of incidents, taking witness statements, information-sharing and following up on reports of alleged abuse provide opportunities to identify patterns of abuse more effectively.

5.5.1 While police objected to bail, the information presented to the Court did not fully reflect Patrick's history of domestic abuse and associated risk across the family. As a result, the full extent and nature of the risk posed by Patrick was not communicated to the Court when bail was being considered.

5.5.2 Information sharing and enquiry were not sufficiently robust to ensure that all relevant agencies and decision-makers had a comprehensive understanding of the history, dynamics, and escalating nature of abuse within the family. This limited the collective assessment and management of risk.

5.5.3 The Review identified a number of occasions where further police enquiries should have been undertaken in response to domestic abuse incidents. These missed opportunities contributed to an incomplete understanding of the pattern of abuse and the level of risk posed by Patrick.

5.6 **Key Finding 5:**

There was no overarching plan to manage the person causing harm in the family, he did not take responsibility for his behaviour, did not seek help, and was not signposted to potential support agencies.

5.6.1 Patrick disclosed two issues whilst in custody; but we found no evidence that Patrick was signposted to appropriate support services following either disclosure.

5.6.2 Currently, there is no policy in place for police in relation to referrals or signposting to Support Services for those who are in custody and presenting with issues. Such a policy or procedure may have assisted Patrick to seek help.

5.6.3 Marta and her child's safety was not assessed during the time her brother t spent in their home, and the only safeguarding available in this case, would have been a perceived risk to the child. In a sense, the message sent to Patrick when he was released on bail, was that nothing was going to happen to him and that his behaviour did not need to change. This is the wrong message, and perpetrators need to know that they will be held accountable.

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 risk; how we assess risk and how we make risk assessment tools work more effectively to ensure that risks become clearer.

6.2 **Key Learning point 1: The need to allay fears about reporting abuse is still needed and harder to reach communities need better access to information such as what happens after arrest, what support options are available etc.**

6.2.1 Domestic abuse crosses all social boundaries and can happen to anyone. Therefore, it is important that we recognise how some victims can face additional barriers to accessing support, because of their age, gender, race, culture, migration status etc. Marta's case reminds us of the importance of developing services that are culturally aware, that understand a victim's culture/cultural background and can identify and develop to meet culturally specific needs, including having language options and addressing intersections between culture and gender/gendered roles within families and communities.

6.3 **Key Learning Point 2: The provision of a bail address for an alleged perpetrator with a history of domestic abuse, must be subject to robust risk**

assessment, and if possible, placing a perpetrator with a history of domestic abuse in a family home should be avoided.

6.3.1 At the time bail was granted, there were no recorded reports of abuse by Patrick towards Marta. Consequently, the risks associated with Patrick going to live in Marta's family home were not fully understood, particularly in the context of his wider pattern of abusive and controlling behaviour within the wider family environment.

6.3.2 Marta indicated that she believed Patrick would comply with expectations and that she would be able to manage his behaviour while he resided in her home. There is no evidence that Marta perceived herself to be at risk from Patrick at that time.

6.3.3 However, information obtained during this Review indicates that both Marta and her child were subjected to controlling and coercive behaviour by Patrick while he lived in the family home. This behaviour formed part of a broader pattern of domestic abuse that extended beyond incidents formally reported to agencies.

6.3.4 The Review concludes that, whilst Marta's death was not predictable, the risk of Patrick directing abusive behaviour towards Marta was foreseeable. His established history of domestic abuse, evidence of escalating behaviour, and the killing of a family pet were significant indicators of increasing risk that warranted greater recognition and consideration.

6.4 **Learning Point 3: Accurate & timely risk assessment is vital if we are to identify risks to victims and assess the risk posed by perpetrators.**

6.4.1 Risk factors relating to Patrick as the alleged perpetrator should have been acknowledged in each of the DASH forms completed as this would have enabled officers to build a history of his risk-related behaviour. Past abusive behaviour is typically a precursor to future abusive behaviour and each incident involving Patrick in this case represented either a repetition or an escalation of his behaviour.

6.4.2 A joined up approach is needed if we are going to improve our understanding of risk. Incident-based risk assessments should be analysed as part of a pattern, helping us

to identify escalating behaviour, and consider the risk posed by the perpetrator. Information from one assessment should inform the next assessment and all assessments should be used to create a more robust picture of what was happening.

6.4.3 Whilst the need to improve risk assessment in this case pertains to the PSNI, Marta's case presents all agencies with an opportunity for learning. The need for collaborative training between several agencies, including PSNI, HSCTs and PBNI etc. that focuses on decision making, risk thresholds for DASH and referrals to MARAC is highlighted.

6.5 **Learning point 4: Improved victim-centred approaches to recording abuse and sharing information enables better identification of risk/vulnerability.**

6.5.1 Risk of abuse in this case involved the whole family and any assessment and information sharing needed to reflect this.

6.5.2 The escalation in Patrick's behaviour prior to his remand and concerns raised by family members about Patrick's behaviour could have led to a referral to mental support services. Family members wanted police to direct him to the help he needed as they knew something was wrong but did not know how to deal with the situation.

6.5.3 There were occasions when statements from key witnesses were not recorded, when offences were missed and there was no follow up in relation to the alleged incidents for example, the abuse of the cat.

6.6 **Learning Point 5: Dealing effectively with perpetrators of abuse is an essential aspect of addressing domestic violence.**

6.6.1 Prior to moving into Marta's home, Patrick had subjected multiple family members to violence, threats and abusive behaviour and had killed a family pet. Taken together, these incidents evidenced a pattern of escalating abuse and increasing risk across the family. Despite the seriousness and persistence of this behaviour, the underlying

pattern of risk was not fully addressed, and family members remained concerned that more effective intervention was required.

6.6.2 The Review found that the risk posed by Patrick to the wider family was not fully recognised, assessed, or managed. Reports of abuse involving different family members were considered as discrete incidents rather than being analysed collectively as evidence of an established and escalating pattern of abusive behaviour. By the time Patrick moved into Marta's home, he had already threatened, abused, or intimidated multiple members of his family, including his father, his father's partner, his mother, and his brother. Despite this, there was insufficient recognition that the risk he posed extended across the family as a whole and was likely to transfer to those with whom he was living. Consequently, the cumulative nature of the abuse was not fully understood, resulting in missed opportunities to identify, assess and respond to the ongoing escalation of risk.

7.0 Overview Recommendations (7)

Agency/Agencies	Recommendation
Domestic Abuse Partnerships/local councils/trusts in each trait area. Rec.1	Locally run domestic abuse campaigns should focus attention on migrant groups, utilising existing services and developing posters and information leaflets in a range of languages. Campaigns need to highlight the nature of abuse, coercive controlling behaviour, and the range of relationships where abuse can happen. Campaigns should adopt a community-based approach working with migrant support groups, women's groups, men's groups etc. to deliver key messages. Increase awareness of DA and CCB in migrant/BME communities in NI. Increase awareness of diverse needs in organisations Increase and improve engagement with migrant and BME communities in NI in relation to DA
SHSCT lead Rec.2	Trusts should develop and strengthen community-based engagement and partnership working with organisations supporting Black, Asian and Minority Ethnic communities, migrant populations, refugees and asylum seekers, Traveller and Roma communities, people with disabilities, LGBTQIA+ communities, older people and other hard to reach groups. Working alongside community and voluntary sector partners will help improve access to services, increase awareness, strengthen safeguarding, and support mechanisms, and build trust with communities that may face barriers to engagement. Partnership activity should be co-designed, monitored, and evaluated, with learning shared regionally to support scalable and sustainable approaches. Learning should be shared across Trust areas. This recommendation extends to all public services. Increased and improved engagement with migrant and BME communities in NI in relation to DA Increased awareness of diverse needs in organisations
TRUSTS -ALL x5 Rec.3	All health trusts should develop a range of information available in a range of different languages, including Lithuanian, Polish, and Portuguese as a minimum. Posters with clear information about domestic abuse should be on display at a wide range of trust and community venues including medical centres, workplaces, hospitals, community mental health offices, PSNI stations etc. Increases in information available in community-based services

	Increased awareness of diverse needs in organisations
PSNI Rec.4	Interpreters working with victims should receive training about abuse, vicarious trauma and they should be made aware of the need for confidentiality in domestic abuse cases. Improved working relationships with interpreters and improved confidence among interpreters in relation to DA Increased confidence in PSNI amongst minority communities Improved standard of investigations where English is not the first language of the victim.
PSNI Rec.5	Recommendation 5a – 5c: Recommendation 5a: The PSNI should develop and implement a service-wide, victim-centred Bail Management and Safeguarding Framework for all domestic abuse and violence against women and girls (VAWG) related investigations. The framework should establish clear governance, accountability, risk assessment standards, safeguarding expectations, supervisory oversight, and multi-agency information-sharing arrangements to ensure that bail decisions and bail management are consistently informed by risk, vulnerability, offender behaviour, and ongoing safeguarding needs. 5b: Where domestic abuse perpetrators are released on bail, PSNI should ensure there is a clearly identified officer responsible for ongoing monitoring, safeguarding contact, and review of bail-related risk, with mandatory recording of actions and review on police systems. 5c: Where an alleged perpetrator is identified as high risk in a domestic abuse context, the responsible officer (as identified under Recommendation 5b) must ensure that a clear and robust risk assessment is undertaken which explicitly addresses the perpetrator's living arrangements and access to any woman, child, or vulnerable adult. This assessment must determine whether it is safe for the perpetrator to reside with, or have contact within the household of, potential victims. Where risk is identified, decisive action must be taken to restrict access and reduce harm, including actively pursuing and securing alternative accommodation for the perpetrator. All decisions, actions, and reviews must be clearly recorded and subject to ongoing monitoring and reassessment. Increased protection of those at risk of harm; increased recording of checks being conducted in relation to bail cases of all types. Improved risk assessment in relation to bail, and increased communication with person/s providing Bail address. Timely updating of police systems when bail addresses are agreed. Improved partnership working with partners such as Social Services, Health trusts, Women's Aid, Nexus, Men's Advisory group, Victim's Support, Assist, the

	Housing Executive, Probation Board NI, Youth Justice Agency, Education Authority, safeguarding organisations and community partners to provide a coordinated response to vulnerability, domestic abuse and safeguarding concerns.
PSNI Rec.6	DASH training needs to focus on a broader assessment of risk, it is important that assessments build a picture of the risks that victims are living with, incident-based assessment does not allow officers to fully understand what is happening. Officers must consider previous assessments, reviewing the history/pattern of abuse captured by previous assessments. Professional judgement is vital and ongoing updates, and bite-sized refresher training is recommended by the panel to support officers. For example, short podcasts, focused bite-sized infographics, quizzes, videos, checklists, animations etc. Enhanced knowledge and competence of police to recognise the occasions when adults may be at risk of harm. Increased and improved quality, accuracy and timeliness of relevant adult protection information recording, retention and sharing with our partners. Increased referrals to MARAC, as well as reduced repeat victimisation and perpetration. Training completion auditing. Decrease in domestic motivated calls being closed without appropriate action and safeguarding
PSNI - Lead HSCT x5 PBNI Rec.7	DASH training must be organised across a range of services including the PSNI, HSCTs and PBNI etc. Training should focus on risk assessment and the DASH and should include a review of current processes and information sharing in relation to decision making, risk thresholds for DASH, grading risk and making referrals to MARAC.

7.1 Agency Recommendations – PSNI (6)

Agency - PSNI **PSNI RECOMMENDATIONS 1-4 RECORDED IN PREVIOUS DHR**	**Recommendation**
HOB Public Protection/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.
HOB Public Protection/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 - Implementation of appropriate and case specific safeguarding measures 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. Improve officer and staff competence and confidence in the use of and standard of DASH risk assessment, increased referrals to MARAC, as well as reduced repeat victimisation and perpetration.

	Decrease in domestic motivated calls being closed without appropriate action and safeguarding.
Lead for Safer Custody Rec.3	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, including mental health services and drug and/or alcohol addiction 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. Highlighting the use of pre-release FMO assessment
HOB PPB/Head of Police College	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 cases of non-domestic reports, a bolt-on or alternative technical solution to the PPN, to facilitate timely information sharing with our partners. **Specific attention should be given within the training to enhancing the knowledge of police to recognise vulnerabilities arising from non-intimate, child-on-parent/adult relative domestic abuse.*

	Enhanced knowledge and competence of police to recognise the occasions when adults may be at risk of harm. Increased and improved quality, accuracy and timeliness of relevant adult protection information recording, retention and sharing with our partners.
HOB Public Protection / PSNI Head of Police College Rec.4	To increase officer awareness of the importance of carrying out appropriate checks in relation to the history of Domestic Abuse perpetrators, with particular focus on cases where individuals have been born or previously lived abroad. This is to specifically include awareness raising around: Consultation with International Liaison where appropriate PNC checks PND checks ViSOR checks. Foreign National Criminal Record Checks via ACRO This will be achieved by: Provision of appropriate training on checks and pathways open to police. Awareness raising on the role of International Liaison and their area of business. Increased awareness of use of police checks to enhance investigative opportunities and risk assessment, and therefore greater protection to victims. Improved quality of information held on occurrences relating to Foreign National suspects/suspects who have resided abroad. Increased inter-departmental contact with International Liaison colleagues
HOB Public Protection/PSNI Head of Police College. Rec.5	To improve officer knowledge of independent interpretation and translation services, and when to use them. To ensure all victims of domestic abuse are offered an independent interpreter where English is not their first language. This will be achieved by: DA Service Instruction to be updated. Foundation Training to incorporate into DA lesson. District Training on DA to include in DA lesson. Awareness raising via POINT/Email in conjunction with partnership working with Migrant Centre NI, to specifically include issues around use of family members as interpreters. **Please note a similar recommendation has been identified in respect of 'Alfie' CMR

	Increased confidence in PSNI amongst minority communities Improved standard of investigations where English is not the first language of the victim Increased outcomes for victims where English is not their first language
HOB Public Protection /PSNI – Head of Police College Rec.6	To increase the protection and safety of those at risk of harm by ensuring: -appropriate checks are carried out on bail addresses proposed by suspects in custody. -All relevant information regarding offending history is presented to the court. This will specifically include: permission being sought from the primary resident and results recorded appropriately. relevant checks being carried out in respect of children living at the address. timely liaison with Social Services regarding any bail addresses where children are resident. This is to be achieved by provision of appropriate training and awareness raising around the bailing of suspects in domestic abuse cases. Increased protection of those at risk of harm; increased recording of checks being conducted in relation to bail cases of all types. Improved partnership working with Social Services Timely updating of police systems when bail addresses are agreed Improved rationale for bail objections being recorded by responsible officers. Improved partnership working with Social Services