Domestic Homicide Review

Overview Report

Portsmouth City Council
Community Safety Partnership

Report into the death of Betty
December 2019

Author – Dr Shonagh Dillon, LLB, DCrimJ
February 2022

Glossary

ACES – Adverse Childhood Experiences

APP – Authorised Professional Practice

ASC – Adult Social Care

BWV – Body Worn Vest (camera)

CCG – Clinical Commissioning Group

CCTV – Close-Circuit Television

CPD – Continuous Professional Development

CSP – Community Safety Partnership

DA – Domestic Abuse

DASH – Domestic Abuse, Stalking and Honour Based Violence

DHR – Domestic Homicide Review

DMI – Digital Media Investigations

DVA – Domestic Violence and Abuse

DVPN – Domestic Violence Protection Notice

DVPO – Domestic Violence Protection Order

GP – General Practitioner

HLDS - Hampshire Liaison and Diversion Team

IDVA – Independent Domestic Violence Advocate

IMR – Independent Management Review

MARAC – Multi-Agency Risk Assessment Conference

MASH – Multi-Agency Safeguarding Hub

NFA – No further Action

NDM – National Decision Making

NPT – Neighbourhood Policing Team

PACE – Police and Criminal Evidence Act

SCAS – Southcoast Ambulance Service

SPP – Safer Portsmouth Partnership

UNODC - United Nations Office on Drugs and Crime

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DHR Overview Report into the death of Betty, December 2019

Preface

The independent author, DHR panel and the Safer Portsmouth Partnership (SPP) wish to offer their deepest condolences to everyone who was affected by Betty's[1] death. We extend our further thanks to those who knew Betty and contributed to this review, their generosity in doing so, considering their loss, is greatly appreciated.

In addition to this the author and the panel would like to extend our thanks to all professionals who responded to the Independent Management Reviews, their time and effort enabled some robust analysis and recommendations.

Finally, the author of the report would like to extend her sincere thanks to the panel members for their professionalism and the considered manner in which they approached this review.

1. Introduction and Background

1.1 This review will examine the circumstances surrounding the death of a 32-year-old woman, Betty, who was murdered in December 2019, by her partner, Paul[2], aged 48.

1.2 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011.They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by-

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

[1] Not her real name
[2] Not his real name

(b) A member of the same household as herself; with a view to identifying the lessons to be learnt from the death[3].

1.3 The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice

1.4 Timescales

This report of a domestic homicide examines agency involvement and responses afforded to Betty, who was a resident of Portsmouth City prior to her death in December 2019.

The review will consider agency contact with Betty and Paul (the offender) for the period of:

Betty – 01/01/2018 to 17/12/2019
Paul – 01/01/2018 to 17/12/2019

This time frame was agreed to be appropriate by all panel members in December 2020.

The referral from Hampshire Constabulary was sent to the CSP on the 24th December 2019. The decision to undertake a DHR was made by Portsmouth City Council Community Safety Partnership (CSP) on 8th January 2020. The Home Office was subsequently informed. On 23rd January 2020 the CSP commissioned Dr Shonagh

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office - December 2016

Dillon to undertake the role of independent author and chair to the panel and the DHR panel was convened. Due to the Coronavirus Pandemic the DHR was delayed, and all meetings took place virtually. The panel members met on the following dates:

- 22nd September 2020
- 10th December 2020
- 15th April 2021
- 1st July 2021

1.5 In Portsmouth, the Health and Wellbeing Board perform the statutory duties of the community safety partnership. The overview report and executive summary were presented to a subgroup of the board - the CSP Responsible Authorities Group - for approval on 9th February 2022 and submitted to the Home Office on 22nd February 2022. The report was considered by the Home Office Quality Assurance Panel on 27th July 2022 and approved for publication on x.

1.6 Portsmouth takes the issue of domestic abuse seriously; the city has an exemplary record of prioritising and commissioning innovative services for victims and survivors of domestic abuse.

The Domestic Abuse Strategy 2020-2023 was approved by Portsmouth's Health and Wellbeing Board in January 2020. Importantly this strategy links in closely with the Hampshire Constabulary domestic abuse strategy, as well as Portsmouth's Violent Crime Unit Response Strategy and the Children's Trust Plan 2020-2023[4].

The strategy is clear and ambitious in its vision, and states:

This strategy aims to make sure that

- *Everyone in the city - especially young people - understand what a healthy relationship looks like*
- *Everyone in the city know where to get the right support for their needs*
- *That professionals understand both the presenting and underlying needs of adults and families struggling with unhealthy or abusive relationships*
- *That there is a clear measurable, process to access the right support and that support is provided for as long as required in order to keep adults, children and families safe*
- *That those who use coercive control, unhealthy or abusive behaviour are held to account and supported to change insofar as this is possible.*[5]

[4] https://www.saferportsmouth.org.uk/domestic-abuse-priority/
[5] https://www.saferportsmouth.org.uk/domestic-abuse-priority/

1.7 People involved in the DHR

Name	Age at time of murder	Relationship with the victim	Ethnicity
Betty	32	Victim	White British
Paul	48	Partner and Perpetrator	Black

Betty had no children. Paul has seven children from several previous relationships, they are all now adults.

The panel has applied the Home Office guidance and has given the pseudonyms identified above to the offender and the victim. It is hoped this humanises the review process and eases the reading of the report. The friends of Betty chose her pseudonym because she had a deep affection of the cartoon character Betty Boop and her friends commented:

'she would have liked the tribute.' (Friend 1 & 2)

1.8 Summary

Betty and Paul were in a relationship for approximately three years, the exact length of the relationship is unclear.

Prior to her relationship with Paul, Betty had been in a relationship with Tommy[6] for approximately ten years. Tommy is described by Betty's friends as the "love of her life", although her friends also describe him as very abusive towards Betty throughout their time together. The relationship with Tommy ended in in approximately 2015/16, at which point Betty began the relationship with Paul. Following the Home Office Quality Assurance Panel letter (see appendix B), the author of the report contacted Betty's friends again to ask for any further detail on how Betty and Paul met. The friends had no knowledge of how Paul and Betty got together, so we could not provide any further analysis on this aspect of their relationship.

From the start Betty's family and friends reported that Paul was 'controlling' and 'needy'. Betty had shown her friends and family members bruises; on one occasion these were bruises to her neck and on another occasion, she had bruises to her wrists. Betty told her friends that Paul was aggressive and possessive, and she wanted to leave him. Betty also explained to her family that Paul had leant her money for cannabis, and he kept a book recording how much she owed him. Betty also disclosed to her friends from work that Paul had struck her head on the wall.

In October 2018 Betty lost her mobile phone in the back of a taxi and had subsequently been subjected to malicious communication from an unknown source. The source continued to release sexually explicit videos of Paul and Betty to everyone on Betty's contact list, this included her family and friends. A Facebook profile was also set up

[6] Not his real name

with sexually explicit pictures of Betty. Whilst all these images were being shared, they were also sent directly to Betty alongside threatening messages from this unknown person. This targeted harassment caused Betty considerable alarm and distress, and she reported it on a number of occasions, as did Paul. The full extent of the malicious communications will be discussed in more detail in the IMR and analysis sections of this report.

One evening in December 2019 Betty went to Paul's house where they spent the evening together. In a police interview Paul stated that he had asked Betty to marry him, and she had said yes. They had spent the evening together and exchanged presents for Christmas, then watched films.

Betty was due to be in work the next day but did not turn up and the taxi driver who regularly picked her up from the same spot said she was not there at the pre-arranged time of 05:30. By the next evening Betty's family were very concerned about her and contacted the police. Paul stated the last time he had seen her was at approx. 05:00 that day when he left for work and turned her alarm off for her. Later in the police interview Paul described how Betty had called him Tommy when she had woken, and he said he knew she had cheated on him at least four times in the past two years.

Paul spent his day at work and on his way home he spent time carrying out several different errands. He had texted Betty throughout the day but received no reply. According to Paul's description of the events, after speaking to Betty's family and the police about her whereabouts, he went home and found Betty in the flat already dead and dialled 999. Paul concluded that someone must have broken into his flat and murdered Betty.

Betty had suffered sharp and blunt force trauma injuries to her head and her neck. Betty also had multiple scalp and facial lacerations and skull fractures mainly to the left side of her head and face. Betty received at least ten blows to the head and a similar number to her arms and hands in what are thought to be defensive injuries.

Paul was arrested at the scene for Betty's murder.

2. Parallel Reviews and Processes

2.1 A Home Office post-mortem was conducted.

2.2 Paul was charged with Betty's murder and subsequently appeared before Winchester Crown court in January 2020, where he pleaded not guilty to her murder.

2.3 Paul was found unanimously guilty of the murder in early 2021, he was also found guilty of disclosing private sexual photographs and films with intent to cause distress. He was sentenced to life imprisonment to serve a minimum of 23 years.

2.4 There were no other parallel review processes arising from Betty's death.

3. Domestic Homicide Review Panel

The DHR panel consisted of the following agencies and professionals:

Job Title	Name
Community Safety Strategy and Partnership Manager	Lisa Wills
Head Harm and Exploitation	Bruce Marr
CEO Aurora New Dawn (Independent author and Chair)	Shonagh Dillon
Head of Southampton, Portsmouth and Isle of Wight - Her Majesty's Prison and Probation Service	Sarah Beattie
Head of Safeguarding Portsmouth CCG	Sarah Shore
Serious Case Reviewer – Hampshire Constabulary	Colin Matthews
IDVA Service Manager – Southampton City Council, Panel Domestic Abuse Specialist	Karen Marsh
Director of Quality and Safeguarding Portsmouth CCG	Tina Scarborough – Minutes only

4. Independence

4.1 The author of this report, Dr Shonagh Dillon, was independent of all agencies involved in the panel. She had no previous dealings with the initial inquiries and no contact or knowledge of the family members.

Dr Dillon is the CEO of a local charity in the area Betty resided therefore due regard was paid to her independence. Mitigation processes via case information were applied by the CSP leads prior to Dr Dillon being commissioned, this ensured Dr Dillon's independence was transparent in this case.

Dr Dillon is a Home Office accredited DHR chair and has nearly three decades of professional experience in the male violence against women sector supporting victims and survivors of domestic abuse, sexual violence, and stalking.

All IMR authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Betty or Paul.

5. Terms of Reference

5.1 The full terms of reference, which were agreed at the first panel meeting and reviewed at the subsequent meetings are included in Appendix A of this report.

5.2 The specific areas of consideration were identified as follows:

- Each agency's involvement with the parties mentioned within the Independent Management Reviews (IMRs) from 01/01/2018 to 17/12/2019
- Whether, in relation to the family members or friends of the victim, an improvement in communication between services might have led to a different outcome
- Whether, in relation to the alleged perpetrator, there are any lessons to be learned in how previous incidents of domestic violence and abuse or offending behaviour were managed.
- Whether the work undertaken by services in this case was consistent with each organisation's professional standards and their domestic violence and abuse policy, procedures, and protocols.
- The response of the relevant agencies to any referrals relating to the victim and or the alleged perpetrator, concerning domestic violence or other significant harm from 01/01/2018 onwards until the point of the death (17/12/2019). It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons.

The scope of the review included, whether there were any concerns amongst family, friends, colleagues or people within the community and if so, how could such concerns have been harnessed to enable intervention and support?

6. Confidentiality and Dissemination

6.1 Whilst it is essential to share key issues with agencies and organisations involved in this DHR, this report will not be disseminated until clearance has been received from the Home Office quality assurance group.

The IMRs will not be published but the DHR report will be made public.

The contents of this report are anonymised to protect the identity of the deceased, family, friends, staff, and others to comply with the Data Protection Act 2018[7].

Once clearance has been approved by the Home Office quality assurance group, the dissemination of the overview report will be published on the Portsmouth City Council website and will be widely disseminated including, but not limited to:

[7] https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

- Members of the Community Safety Partnership
- The Portsmouth Safeguarding adult's board for dissemination to all partner agencies and Local Safeguarding Adult Boards
- The Office of the Hampshire Police and Crime Commissioner
- The Domestic Abuse Commissioner

6.2 The Portsmouth Domestic Abuse Strategy Group will be responsible for monitoring the implementation of recommendations.

7. Methodology

7.1 Following the decision to conduct this DHR, Hampshire Constabulary provided the panel with a timeline of the investigation. Subsequently, several other statutory and voluntary sector agencies were asked to return a summary of their involvement to help the panel understand and analyse any interactions agencies had with Betty and Paul during the specified review period.

Having considered the summaries, the following Individual Management Reviews (IMRs) were requested:

a) Hampshire Constabulary
b) National Probation service
c) Adult Safeguarding
d) Mental Health Services
e) General Practitioners (same Surgery for Paul and Betty)
f) South Coast Ambulance Service

7.2 The Terms of Reference guidance set out the purpose and the scope of the review and the panel focused specific questions to each agency whilst undertaking the analysis of their involvement. The questions were as follows:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

(d) The quality of needs/risk assessments undertaken by each agency in respect of both parties.

(e) Whether there were opportunities for professionals to routinely enquire or any missed opportunities to identify if there was domestic abuse in the relationship

(f) The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of victims.

The authors of the IMRs are independent in accordance with the Home Office guidance[8].

7.3 This report is based on:

- The findings of the IMRs
- Further requested information and analysis resulting from the IMRs
- Interactions with Betty's friends

The IMRs are set out below (see section 9). Each IMR author offered single agency recommendations which are presented in section 14 of the report. The panel have reflected and commented where they felt that single agency actions needed further clarity.

The full recommended action plan is presented in section 15 of this report.

The conclusions and recommendations are the collective views of the Panel, which has the responsibility, through the participating agencies, for implementation of any improvement recommendations.

8. Involvement of Family and Friends

8.1 **Betty**

Betty's family were referred by Hampshire Constabulary to specialist advocacy services for family members through the Victim Support Homicide Service[9]. Both Betty's parents and her brother had sought support from the victim support representative.

The chair of the panel initially wrote to Betty's family members in March 2021, contact was made and agreed through their victim support liaison worker. Betty's brother and father declined to be involved. Betty's mother, Joyce[10] did initially want to meet with the chair and a face-to-face meeting was arranged but Joyce did not attend. Subsequently the chair contacted Joyce one more time to offer another meeting, but

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[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf (Section 7)

[9] https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service/

[10] Not her real name

she declined any further involvement with the review process. The chair remains in contact with the victim support worker and the final report will be sent to her to pass on to the family, should they wish to read it, post publication.

Through the support of the Hampshire Constabulary representative at panel, the chair reached out to three of Betty's friends. All three friends agreed to meet with the chair and these contacts illuminated the review considerably. Throughout the report the views and perspectives of Betty's friends on specific incidents and aspects of the case will be referenced from their perspective and from disclosures she made to them.

A vital element of these meetings was that Betty's friends were able to provide the chair with the following portrait of their friend:

> *Betty was kind, the kindest girl you would ever meet! She was loyal and so very funny. Everywhere she went she had a smile for everyone, so much so that you knew when Betty was sad because she was usually so bubbly. Betty constantly sang, she was always humming, no specific tune, just a constant happy sing song that you could hear everywhere she went. Betty loved her family and her friends very much; she would do absolutely anything for them and often placed their needs above her own to her detriment. She was often seen on pay day buying food and gifts for everyone else before seeing to her own needs. Betty took huge pride in her job and she was very dedicated to it, she was happy at work and gained friends that soon became an extension of her family. Her work colleagues described her as incredibly hard working, very reliable and an utterly beautiful but vulnerable woman. Betty loved horse racing and she frequently came up with tips for her friends to place bets on the right horse. Betty's one major wish in life was to be a Mum, that is all she ever really wanted, and her friends all thought she would make an amazing parent as she had so much love to give. May she rest in peace.*

All Betty's friends miss her very much and the panel were incredibly grateful for their time in responding to this review, the views of Betty's friends are interwoven throughout the analysis (Section 10). Without the views of Betty's friends, the report would have been considerably less impactful.

8.2 **Paul**

The chair of the panel wrote to Paul in prison on 05/07/2021. There was no response to this correspondence and after liaison with the National Probation Service representative, the Chair made no further attempt at contact.

None of Betty's friends had any observations to make about Paul as none of them had met him and although the chair asked for comment on Paul's character or persona from any disclosures Betty made, all Betty's friends remarked that she never talked about him in any detail.

An attempt by the chair was made to contact Paul's ex-partner on 17/08/2021, after she consented to contact via the police, a message was left but no response was received. The chair tried again a few days later but again no response was received. Following further discussion between the chair and the police representative there was intelligence to suggest that Paul's ex-partner was back in contact with him, and the decision was made not to further interrogate his history of domestic abuse towards her. This does limit the report analysis on where previous interventions could have been made with Paul.

The review author did consider contacting Betty's ex-partner, Tommy, but after speaking to the police representative, and to Betty's friends, the decision was made not to contact him, due to his own vulnerabilities.

The panel did not contact the taxi driver who picked Betty up for work every morning. Portsmouth is a small city and due regard was paid to ensuring that confidentiality of the review was paramount to mitigate any further distress to Betty's family and friends.

Every attempt was made to gain the perspective of Paul and any others who knew him for this review, but due to the lack of information this review is limited on its analysis from the perspective of the perpetrator in this case.

9. Independent Management Reviews – Overview

9.1 The following agencies had no information about either Paul or Betty within the timeframe requested by the panel:

- Mental health services
- National Probation services

9.2 The following agencies provided IMRs in relation to Betty only.

- Safeguarding Adults
- South Coast Ambulance Service (SCAS)

Key Events – Chronological order:

9.3 Chronology of known Key Events for Betty

	Incident	Date	Agency/s Aware
1(a).	Betty reported to 111 that Paul had smashed her head against the wall. The police received the referral	August 2018	• SCAS • Adult Safeguarding • Police
2(a).	Malicious Communications – Online sexual abuse. Betty reported that sexually explicit videos of her and Paul had been sent out to her boss	October 2018	• Police
3(a).	Betty called 111, she reported that she had been drunk the night before and now had back pain. Paul had told her she had fallen down 3 or 4 stairs.	February 2019	• SCAS
4(a).	Malicious Communications – Online sexual abuse. Betty reported further online sexual abuse. Sexually explicit content had been sent to her family and others on her contact list.	August 2019	• Police

9.4 Chronology of Key Events for Paul

	Incident	Date	Known to - Agency/s
1(b)	Paul reported Betty to the police for slapping his face in an argument which made him fall backwards. He stated Betty had punched him in the chest and grabbed him around the throat. Paul told the police that Betty was under the influence of drugs and alcohol and they had engaged in sex. During intercourse Betty had called him by her ex-partner's name (Tommy). At which point they started arguing. *NB – two days after the incident Betty reported see 1(a) above*.	August 2018	• Police
2(b)	Malicious Comms – When Betty reported the continuing incidents of malicious communications, Paul was also present, and both Betty and Paul disclosed that he had been subjected to racial abuse in these messages.	August 2019	• Police

9.5 Individual Management Review – SCAS (Betty Only)

The South Coast Ambulance Service (SCAS) manages various contracts across the Hampshire area. The two pertinent contracts in relation to this review are for the 111 service and the 999 and ambulance service.

During the review timeframe SCAS received three calls from Betty. There were no records within the timeframe for Paul.

- *Incident one - see chronology 1(a)*

9.5.1 Betty called 111 on August 27th, 2018. She said that her boyfriend [Paul] had smashed her head against a wall.

The ambulance records state that Betty and Paul had both used alcohol and drugs the night before. Betty disclosed that after an altercation, Paul had dragged her into hallway and banged her head against the wall. Paul had left the scene prior to the crew arriving.

Betty had called 111 for medical advice and the records state that she was not expecting an ambulance. Betty was given advice on the status of her injuries. She told the paramedics that she would be moving out of the property that day. She also stated that she will not be pressing charges against Paul. The crew gave Betty advice on what to do if health symptoms deteriorated.

The IMR author noted after the call was complete the clinician sent a written safeguarding referral, which was subsequently read by the automatic system and sent incorrectly to the Hampshire Adults Multi-agency Safeguarding Hub (MASH). This referral should have been sent to Hampshire police and Portsmouth MASH, which was picked up and sent appropriately the following day.

- *Incident two - see chronology 3(a)*

9.5.2 The second incident was on February 9th, 2019. Betty called 111 to seek advice regarding back pain. An ambulance was dispatched. The history was recorded as Betty '*was very drunk the night before. Her partner had said that she had fallen down 3 or 4 stairs. She was now complaining of back pain'.* The IMR noted that there were signs and symptoms of head injury to Betty. The crew did not admit Betty to hospital but did give her advice on symptoms that would require her to seek further medical attention.

Betty's Mum was with her at the time, and Betty told the ambulance crew that she was going home with her.

- *Incident three – Murder*

9.5.3 The ambulance arrived at Paul's flat after he called them. The crew recognised Betty as 'life extinct'.

9.5.4 IMR author's Learning points:

Learning point 1: The IMR author recognised that the police should be called for a patient who has come to harm because of domestic abuse. After the attack on Betty in incident one the Joint Royal Colleges Ambulance Liaison Committee clinical guidelines pocketbook[11] was updated to include an automatic referral to the police for domestic abuse cases. Although Betty was referred to police the next day (within the timeframe required) SCAS have updated their communication with all staff to ensure they are aware of their duty to contact the police on cases of domestic abuse.

Learning Point 2: The author also recognised the safeguarding referral was sent off to the wrong social services and police MASH, the likely issue was due to the referral being handwritten and not being read properly by the server.

9.5.5 Panel Observations

On the two occasions Betty called for help resources were dispatched and arrived quickly. This gave clinicians the opportunity to have eyes on what the circumstances were at point of crisis for Betty.

The panel felt that the IMR author recognised the need to refer immediately to the police on incident one but failed to recognise the need to do the same on incident two (see chronology p.15). The panel agreed both incidents should have prompted a referral to safeguarding and to the police – especially as Betty had willingly disclosed information about the abuse to professionals during incident one. Although training and policies are essential when working with victims of domestic abuse, the paramount skill professionals require is professional curiosity. It appears that the professionals missed the opportunity to ask further questions on incident two and this will be explored further in analysis under routine screening (Section 10.9).

The panel had sight of the internal communication document (see learning point 1 above) and were impressed with the clear and concise nature of the expectations of SCAS staff for victims of domestic abuse.

Further, it was recognised that consent is not needed from victims of domestic abuse to contact the police. This is especially important in Betty's case, as will be discussed further in the analysis (Section 10), Betty would have been unlikely to feel able to be proactive in seeking support from external agencies about her experiences of abuse by Paul. A timely referral to the police and a positive response from safeguarding professionals could have navigated a gateway into other support services for Betty.

[11] https://aace.org.uk/news/new-jrcalc-2019-clinical-guidelines-now-available/

9.6 Individual Management Review – Hampshire Constabulary (Betty and Paul)

Hampshire Constabulary were aware of all but one of the key events in the chronology (see 9.4 & 9.5). They were unaware of event 3(a) – in this incident Betty had called 111 stating she was experiencing back pain and Paul told her she had fallen down the stairs the night before when she was drunk.

Hampshire Constabulary were the only agency aware of all key events relating to Paul.

- *Incident one - see chronology 1(a)*

9.6.1 Police attended the address of Paul and Betty following the referral from SCAS to the Multi-Agency Safeguarding Hub (MASH). Betty informed attending officers that she did not wish to provide a statement, Betty also claimed that she was not fearful of Paul and had since ended their relationship.

A Domestic Abuse Stalking, Harassment and Honour Based Violence (DASH), risk assessment[12] was undertaken with Betty and was categorised as standard risk by the attending officer. The local MASH standard operating procedures defines standard risk as occurrences '*where no risk indicators are present'*.

The risk from Paul to Betty was subsequently re-graded and increased to medium risk by professionals in the MASH. Medium risk is defined as *'there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown and drug or alcohol misuse'.* A safeguarding working sheet was also completed, and warning markers were added to Hampshire Constabulary's database system assessing Betty as medium risk of domestic abuse/violence from Paul.

9.6.2 IMR author's learning points incident one:

The author raised three learning points on incident one.

Learning point 1: The author noted the delay in the referral from SCAS meant that the referral may not have been read properly by attending officers, following this Betty's reliance on alcohol and drugs was not picked up and no services were offered to her as part of discussions to engage her in support.

The author noted the discrepancy between the DASH risk assessment being categorised as standard risk and commented that this assessment is usually reserved for incidents where '*no risk indicators are present'*. Even though this incident included physical violence. The Sergeant also agreed with the attending officer and graded the risk to Betty as standard, using the rationale that Betty disclosed to officers that she had ended her relationship with Paul. The IMR author correctly identities the act of

[12] https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009.pdf

leaving a domestic abuse relationship elevates the risk to the victim and is categorised as a high-risk factor[13]. This assessment is further supported through the analysis in the ten-year Femicide Census[14] which evidences the act of leaving a domestic abuse relationship as the most likely time a woman will be murdered[15].

The MASH upgraded the risk to Betty as medium noting the added vulnerability of Betty's drug and alcohol misuse as a reason for a risk increase to her.

The author noted that Hampshire Constabulary have already progressed the learning regarding dynamic risk assessment and domestic abuse risk indicators such as separation due to an ongoing DHR in Hampshire force area, therefore the author did not propose a further recommendation on separation risk as this learning is already being addressed. The review author confirmed with the Hampshire Constabulary lead on the panel that this learning was already being addressed and this was confirmed. In addition, all officers in force undertook mandatory Safe Lives 'DA Matters' training in 2018[16], which also covers risk factors frequently present in domestic abuse situations, including the presiding issue of coercive control.

Furthermore in 2020 Hampshire Constabulary launched the DA Strategy and Tactical Plan, which is tracked and governed by the force Domestic Abuse lead. The plan continues to improve how Hampshire Constabulary identify and assess risk via DASH scrutiny panels, ensuring domestic abuse appears in Continuous Personal Development (CPD) plans of officers and staff. These panels include multi-agency professionals from specialist agencies supporting victims of domestic abuse. In addition, initiatives such as the introduction of a safeguarding plan template which will be embedded into police computer systems to create regular prompts for officers to review risk and safeguarding needs, throughout the course of an investigation.

Learning point 2: The author alerted the panel to the fact that no 'golden hour enquiries' were undertaken in the preliminary investigations after incident one. For example, it appears house to house enquiries were not recorded as completed, and as suggested previously there appears to have been no contact with health colleagues or other possible witnesses. Completing such enquiries strengthens an investigation and later enables further consideration as to whether there is an opportunity for an evidence led prosecution, should the victim not wish to engage in the criminal justice process.

The current Force Policy states:

> *'In line with the "golden hour" principles, and National Decision-Making Model (NDM)[17], all available evidence must be identified and secured at the earliest opportunity; including evidence from independent witnesses such as other family members, or neighbours.'*

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[13] https://www.dashriskchecklist.co.uk/wp-content/uploads/2016/09/DASH-2009-2016-with-quick-reference-guidance.pdf

[14] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

[15] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf (p.30)

[16] https://safelives.org.uk/training/police

[17] The National Decision Model is a decision-making process, that is used by police forces across the country to assist in assessing risk. It provides five different stages that officers can follow when making decisions.

Learning point 3: The IMR author notes, following Betty's disclosure of domestic abuse there was no positive action taken by officers against Paul. Hampshire Constabulary policy should have led to Paul's arrest. The rationale given by officers in this case were multiple:

a) Betty did not support an investigation
b) Betty had no visible injuries
c) There was a delay in the referral to the police

As a result of the above the decision was taken not to arrest Paul or request that he present himself for voluntary interview.

The IMR author asserts that this incident did necessitate an arrest of Paul, as set out in the Police and Criminal Evidence Act (PACE) 1984 Code G[18], paragraph 2.9 (d): *'to protect a child or other vulnerable person from the person in question'*, and both the failure to do this alongside the lack of preliminary investigations left Betty without the appropriate safeguarding.

Arrest is not predicated on the victim's willingness to engage; this is especially important in cases of domestic abuse. If Paul had been arrested, one of the outcomes of the investigation could have been 'no further action' (NFA), in line with the Acting Sergeant's rationale, but this would not negate consideration for further safeguarding measures. For example, consideration of a Domestic Violence Protection Notice[19] (DVPN) could have been explored on the basis that the investigation was likely to be NFA. The IMR author considered the medium risk assessment and the presence of other risk indicators, including separation, would warrant exploration of a DVPN/DVPO to reduce further risk.

Perhaps most importantly the IMR author notes that this incident was not delayed in referral to the police because of Betty, but because of a delay in organisational process from SCAS. However, the delay of approximately two days led the acting sergeant to deem this incident as 'non-current'. The IMR author asserts the following:

"The current Force Policy that refers is policy 02400 'Responding to and Investigating Domestic Abuse', paragraph 3.2.9 states:

'In the case of non-current reports discretion must be exercised when considering what positive action to take and consultation with partner agencies, where appropriate, will be important in deciding upon the best approach.'

There is no stipulation within policy as to timeframes for a 'non-current' report."

[18] https://www.legislation.gov.uk/ukpga/1984/60/contents
[19] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010

- *Incident two* – see chronology 1(b)*

*NB – this incident took place two days after incident one above

9.6.3 Police attended Paul's address after he reported Betty had assaulted him during an argument. Paul claimed that Betty had been under the influence of drink and drugs when she had turned up at his home earlier that day. He invited her in, and they had sex. During intercourse, Paul claimed that Betty had referred to Paul by an ex-partner's name. This angered Paul, who then left the bedroom. According to Paul's report Betty followed and an argument ensued where Betty slapped Paul across the face, causing him to fall backwards and hit his head on the floor. Paul alleges that Betty then began punching him in the neck and chest and grabbed him around the throat.

Betty was arrested for the assault of Paul and after being searched in custody she was subsequently arrested for the Possession of Class A and Class B drugs. Betty later pleaded guilty at court to both charges and was sentenced to a 6-month Conditional Discharge, and a series of fines.

As a result of the incident Paul was assessed as being at medium risk of domestic abuse. He was offered independent specialist domestic abuse support services but declined. A safeguarding working sheet was completed for Paul and a warning flag (marker) was added onto police systems on the home address of Paul to alert any calls from the address as a priority.

9.6.4 IMR author's learning points incident two:

The author raised a further three learning points on incident two.

Learning point 4: counter allegations are a common tactic from perpetrators of domestic abuse (analysis of this by the panel will be discussed further in coercive control section 10.1). The IMR author records that Betty told the arresting police officer "*I did assault him, he deserved it because he hit me last night.*"

The College of Policing Authorised Professional Practice (APP) refers to 'First Response Guidance to Domestic Incidents', paragraph 3.5[20] states:

> *"Counter-allegations require police officers to evaluate each party's complaint separately and conduct immediate further investigation at the scene (or as soon as is practicable) to determine if there is a primary perpetrator. If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the party being arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one."*

[20] https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/first-response/#determining-the-primary-perpetrator-and-dealing-with-counter-allegations

The IMR author notes that Betty disclosed she was assaulted "*last night*", however it is not clear if this refers to the previous assault two days before or she is reporting a further assault. The attending officers did not record a counter-allegation on the police system, and there is no evidence of investigating officers exploring if Betty was referring to the reported assault from days previous, or to a new incident of abuse from Paul.

Interestingly on police attendance at the address, Betty was in a state of undress and under the influence of alcohol and drugs. In contrast Paul is described as "*calm and compliant*" with Betty being described as "*highly emotional*" and "*agitated*". When advised of her arrest, Betty had to be restrained by officers on the floor and removed from the flat. The author notes her concern that Betty's use of substances may have resulted in an unconscious bias from officers, and this may have skewed their view of her.

Analysis of the body-worn video footage (BWV) of the arrest captures Betty repeatedly saying, "*no one believes me"*. The BWV positively documents an understanding and considerate approach towards Betty by an attending officer. The attending officer is gentle in their response towards Betty who is very tearful throughout. The officer informs Betty that she will have the chance to explain what has happened during interview.

Had this line of enquiry been pursued with Betty and procedure followed, this would have initiated a DASH risk assessment and further disclosures may have been made by Betty. This was not done, and therefore Betty was treated as the primary perpetrator and not as a victim.

<u>Learning point 5</u>: The IMR author raised risk escalation with regards to Betty, having analysed the recording of incidents. It was recognised following Betty's discourse during the above record that this could potentially have been the third incident of domestic abuse within a week.

As previously acknowledged by the IMR author in relation to the incident a few days before, when Paul allegedly assaulted Betty, nobody undertook a risk assessment with her. But on this occasion Paul *was* risk assessed. Within this assessment he disclosed that the abuse was *"getting worse and more frequent"*.

Further conversation with attending officers records Paul referring to incident one, and he stated:

> "[Betty] *hit him again, he told her to get off and ended up grabbing her by the throat to stop her and she flopped and banged her head on the wall, she called 111 (ambulance) and they [the ambulance] called police*".

As the IMR author points out this is an admission to the assault in incident one and this should have been revisited and investigated.

The IMR author felt sure, had this admission of asphyxiation and assault by Paul been appropriately investigated, the MASH risk grading for Betty would have increased the

risk from medium to high risk[21]. A high-risk categorisation deems the victim to be at risk of serious harm or murder and thus the case would have been automatically referred to MARAC and Betty would have been contacted by an independent domestic violence advocate (IDVA).

Learning point 6: The IMR author notes the narrative throughout police records for incident two, that Paul wants to continue the relationship despite Betty telling police within her interview that the relationship is over. This is the second time in three days that Betty has informed police that she is attempting to end the relationship and the author suggests this risk information should have been captured on a new DASH form, as per learning point 4.

Despite this information being disclosed by Betty in interview, it was not passed on to the detention officers in custody and therefore Paul is contacted to collect Betty from custody, and although Betty consented to this, there is a clear indication that the relationship is ongoing and/or that Betty is unable to leave Paul. If the DASH form had been correctly applied this would mean Paul may not have been asked to collect her.

Learning point 7: Once detained, Betty would have been subjected to a custody pre-release risk assessment. Within this risk assessment Betty's drug and alcohol problems were noted and she further disclosed that she was suffering from an eating disorder. Whilst Betty did not disclose any thoughts on self-harming to officers, she was observed "*banging her head against the door softly*" and is described as "*acting erratic*". The pre-release risk assessment, however, did not document any safety planning for Betty or signpost her to referral agencies as is the suggested course of action in force policy.

The IMR author did provide a Progress Update to the Custody Risk Assessment issue raised in learning point 7**:**

- Hampshire Constabulary now ensure that all women in custody are seen by Hampshire Liaison and Diversion Team (HLDS). This assists with identifying needs and signposting individuals to appropriate support services. Further to this there is a programme of Continued Professional Development (CPD), for custody staff, which will incorporate a refresh of the risk assessment in the custody environment.

Learning point 8: Post charge bail conditions were not applied to Betty and Paul. The IMR author observed that if the bail conditions had been applied then appropriate safeguarding could have been undertaken between charge and court, and a period of separation may have enabled Betty to have no contact with Paul. Given the information detailed in the IMR, the author felt the levels of risk should have necessitated bail conditions. However, at the time post-charge bail conditions were

[21] https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face

under utilised within Hampshire Constabulary, particularly in domestic abuse cases where the parties were not co-habitting. Hampshire Constabulary have now embedded a template within the bail log record, ensuring post-charge bail conditions are considered in every case. If bail is not imposed, then a justification must be recorded.

- *Incidents and events surrounding malicious communications – see chronology 2(a), 5(a), 3(b)*

9.6.5 In October 2018 Betty reported online sexual abuse and malicious communications to the police. As far as Betty was aware, she had either left her phone in the back of a taxi or it had been stolen.

Following the loss of her phone intimate photos and videos had been sent to all her contacts listed on the phone. The police stated they were unable to identify a suspect as the CCTV in the taxi had not been working that day.

Safeguarding advice was provided to Betty, including asking her contacts to block her old number to prevent further offences and contacting her phone provider to see if there's anything they can do to prevent further use of the phone or its content. Betty was encouraged to report any further incidents that affected her or anyone she knew. Betty was offered a referral to victim services, but she declined saying she had family support. No further investigation was undertaken.

In August of 2019 Betty again reported receiving abusive messages from an unknown telephone number. In addition, nude photographs of Betty and videos of her and Paul engaging in sex had also been posted online and sent to various people on her contact list. Betty disclosed that this included her father, brother, and work colleagues. When reporting this incident Paul was present and he simultaneously disclosed being subjected to racial abuse within these messages.

9.6.6 IMR author's learning points – Malicious Communications:

The IMR author noted there was a delay in the investigation of the report Betty made in August of 2019, this was due to queries in relation to a Charter application[22]. The investigation remained with the Neighbourhood Policing Team (NPT) for the officer involved in the case to gain experience with Charter applications. It was not until October 2019 that an Acting Police Sergeant forwarded to the investigations team.

A suspect was identified (a previous acquaintance of Betty whom she had been intimate with) and arrested but released due to inadequate evidence.

[22] A Charter application is a request to extract communication data from an electronic device (such as a mobile phone) where a crime is believed to have been committed.

Both the reported incidents in October 2018 and August 2019 are now known to be connected to Paul. During the murder trial it became apparent that Paul had Betty's old mobile in his possession and carried out the malicious communications against her whilst she was alive and in a relationship with him.

The author can find no indication that officers missed opportunities to identify Paul as the offender of the malicious communications, at point of report, Betty was asked who she thought was sending the texts and she stated that she did not '*suspect him [Paul] at all'*. Paul also ensured he was the recipient of the text messages and of racist abuse.

Learning Point 9: The delays in the investigation due to the Charter application were noted by four different Sergeants, but not escalated. Hampshire Constabulary also have Digital Media Investigators that can assist with cases where people need support with enquiries that are digitally based that could have been utilised.

9.6.7 Panel observations

The panel observed the level of detail and analysis of this IMR to be exemplary. The author went to great lengths to ensure the panel were provided with all the information to hand and the author cast a critical eye across the interventions with Betty and Paul, and the subsequent policy discrepancies. This was commended by the panel.

Further information was requested of the IMR author to clarify various aspects of the report. This included:

1. Copies of the DASH risk assessments undertaken for both Betty and Paul

With the benefit of hindsight had Betty been afforded the appropriate interventions with regards to disclosure and risk assessments she would have likely reached the high-risk threshold for domestic abuse via the DASH risk model. This would have afforded her the opportunity to be referred to a specialist Independent Domestic Violence Advocate[23], and her case would have been heard at a Multi-Agency Risk Assessment Conference[24] (MARAC). The MARAC would have provided an opportunity for a more holistic intervention and approach to the case and could have provided more information sharing with regards to Betty's situation.

2. Antecedents of Paul in relation to his ex-partner

A statement was read by the author of this report regarding previous allegations of domestic abuse. The author of the report reached out to Pauls ex-partner on two separate occasions after she consented to be contacted, but these attempts at contact were not reciprocated. This prevented further analysis of any previous domestic abuse

[23] https://safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf

[24] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

history where interventions could have been made with Paul, this is a noted limitation on the report findings.

3. After the panel received the Home Office Quality assurance letter a further discussion was had with regards to whether Domestic Violence Disclosure Scheme[25] would have been applied in relation to Betty. Given the fact that Betty was already being subjected to domestic abuse by Paul, the panel felt that this would not have been sought in Betty's case. Clarification of the current process for referring medium risk victims to independent specialist services

The reviewer confirmed that since October 2019, all medium risk DASH assessments are now referred to commissioned services if victim consent is obtained.

9.7 Individual Management Review – Safeguarding Adults (Betty only)

- *Incident one - see chronology 1(a)*

9.7.1 Following the incident in August 2018 when Betty had called 111 to report that Paul had smashed her head against the wall, Adult Social Care (ASC) received a referral through the Multi-Agency Safeguarding Hub (MASH), from SCAS (see cross reference 9.6 – Incident one – chronology 1(a) p.15).

This referral detailed the incident as well as explaining that Betty had consumed alcohol and drugs at the time of the incident. After reviewing the referral, the decision was taken within the MASH that Betty did not have any care and support needs and therefore a s.42[26] safeguarding duty was not triggered, no follow up action was taken, and nobody contacted Betty.

9.7.2 IMR author's learning points and recommendations:

Learning Point 1: The IMR author recognised a failing in the support of Betty. The referral into the Adult MASH was triaged without consideration of the impact of Betty's substance misuse. The IMR author felt it would have been appropriate to have contacted Betty to discuss the referral and ascertain her views and whether she wanted support/services. As a result, policy has changed within the adult MASH, the panel requested clarification as to how the new policy and procedure could be checked. The IMR author confirmed that regular audits would be undertaken to review this new procedure and audits will commence in the Spring of 2022 (see s.14 single agency action plan ASC).

[25] https://www.gov.uk/government/publications/domestic-violence-disclosure-scheme-pilot-guidance
[26] https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

9.7.3 Panel Observations

The panel commented on the clear and concise details of this IMR and the swift response to any questions asked from the panel to the IMR author. The panel were encouraged by the work already being undertaken in response to Betty's case.

9.8 Individual Management Review – General Practitioners (Betty and Paul)

Betty and Paul attended the same GP surgery. Within the timeframe stipulated by the panel (a two-year period) the GP saw or had an interaction with Betty twelve times and Paul attended the surgery five times.

The GP was made aware of both the SCAS call outs (see chronology 1(a) and 3(a)).

(NB: The author has reproduced only the relevant health issues regarding Betty and Paul, this is to ensure the privacy of both parties)

Betty

9.8.1 In January 2018 Betty presented at the GP surgery with depression and anxiety. The GPs notes also record use of an excessive use of alcohol and drugs. Betty was prescribed anti-depressants and no further referral was made to any psychological support. Betty was advised to follow up in three to four weeks.

Betty did call back to the surgery just under two weeks later asking for a stronger prescription of anti-depressants, the request was agreed, and the GP asked Betty to follow up with them for psychological support. There was no record of Betty getting any further support and she did not attend for any more mental health related appointments.

9.8.2 Between April 2018 and October 2019 Betty attended and or called the surgery on ten separate occasions for four separate medical issues. For all these issues the recorded notes either state that there was no safeguarding or mental health issues 'declared' or 'raised', or there is no record of these issues being considered. A further note by the IMR author states '*nor is there a suggestion that this should have been suspected based on information available or provided at the time'*.

The panel noted that Betty was not screened by any of the professionals in the GP surgery as to whether she was experiencing domestic abuse at any point.

9.8.3 IMR author's learning points:

Learning Point 1: The IMR author felt that the presiding issue to be raised was to follow up with the safeguarding issues resulting from the SCAS referral. The author suggested that administrative teams should place an alert on files where safeguarding referrals have been made.

Learning Point 2: The IMR author also notes that the support services available for recreational drug use are not as easily accessible as support services for alcohol misuse, and this may need to be explored. The IMR author suggests that although there was documentation of advice on alcohol and drug cessation, this is not clearly defined. The IMR author suggests 'considering a way of conveying options available on a leaflet that can be sent as a text on the phone to help improve this'.

Learning point 3: The IM author notes that a referral to counselling services could have been appropriate for Betty, but then further asserts that Betty was already aware of them and had been provided with details of how to make contact. Therefore, the IMR author is of the opinion that Betty wouldn't have used this service anyway.

Interestingly for the panel, the IMR author notes there were ample opportunities for Betty *'to ask for help within her consultations subsequently which were all around other physical problems. She actually discussed her mood in January 2018 earlier that year, started antidepressants temporarily but never opted to continue them or discuss her mental health further.'*

9.8.4 Panel Observations

The panel observed the quality of the report was not as thorough as the other IMRs submitted. The author appeared to be focused on whether the murder of Betty was foreseeable or preventable rather than focusing on lessons learned. The report lacked reflection and reads defensively, which in essence means the panel were not confident that the GP practice had employed the professional curiosity expected when tragedies like these occur.

In addition to the poorer quality of the IMR from the GP, there was a significant delay in receiving the IMRs for both Betty and Paul from the GP surgery. After the initial requested deadline from the panel, further correspondence and requests from the chair were made, finally the clinical lead on the panel had to intervene. The GPs surgery were over two months late in responding to the request. It is feasible to assume that the COVID19 pandemic did have an impact on the timeliness of the IMR report, nonetheless, this significantly delayed the work of the panel and recommendations will be made for IMR author support and or specific posts within health in the Recommendations (section 14).

The lack of routine enquiry from the GP asking Betty whether she was experiencing domestic abuse was of significant concern. As was the professional curiosity expected of professionals working within a GP setting. This will be discussed in more detail in

the analysis section 10.9, under routine screening and has been suggested as a recommendation by the panel (see S.14).

The panel felt it important to note that the most important aspect of cases like Betty's is that every professional is responsible for their own professional curiosity in asking questions of their patients/clients regarding safeguarding, mental health, drug and alcohol issues and or possible domestic abuse. Reliance on other professionals and processes to pick up these issues inevitably means that victims will get missed. The panel discuss this issue further in the analysis section under routine screening (see 10.9).

Paul

9.8.5 Paul's attendances at the GP surgery were infrequent and all appointments related to physical issues.

9.8.6 Paul's use of alcohol was recorded to be '*hazardous*'. This was self-reported as part of Paul's registration with the practice. Paul was offered but declined any support for his alcohol use.

9.8.7 The further four appointments recorded were for general health issues.

9.8.8 IMR author's learning points

Learning Point 3: As there were no safeguarding issues raised and or other emergency visits from other health partners there was a lack of need for intervention on behalf of the GPs surgery for Paul. The only possible avenue of support was for Paul's alcohol use, but the IMR author noted that during other discussions Paul had disclosed his drinking had reduced.

Learning Point 4: It is important to remain alert to safeguarding issues and always continue to offer support for drug and alcohol difficulties.

9.8.9 *Panel Observations*

The panel felt that learning point 4 above would need to be more specific for professionals to action. To 'remain alert' is a subjective positioning and in order to ensure that professionals have clear guidance on their duties under safeguarding they are expected to adhere to the policies and procedures provided to them.

The panel had no other specific observations with regards to the IMR for Paul. Given the lack of engagement with the GP, the detail of the report was appropriate in its context for the purposes of this review.

10 Analysis

The benefit of hindsight enables the Chair and the panel to assess where different decisions or actions could have been a catalyst for support and or intervention for Betty. This analysis is based on information provided in the IMRs and, perhaps more importantly, Betty's friends provided a focus for the panel to understand a more holistic perspective of the situation.

10.1 Coercive Control

Coercive control legislation came into effect in the UK on the 29th December 2015 and was therefore in force as a crime when Betty was murdered. Thus, it is important to analyse this as a potential factor in the relationship between Betty and Paul. Therefore, the following analysis section is presented by the author with the dynamic of Paul potentially asserting coercive and controlling behaviour over Betty. To understand domestic abuse holistically we must understand that coercive and controlling behaviour acts as the backdrop to physical and or sexual violence[27].

The cross-Government definition of domestic violence and abuse outlines controlling, or coercive behaviour as follows:

- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

- Controlling or coercive behaviour does not only happen in the home; the victim can be monitored by phone or social media from a distance and can be made to fear violence on at least two occasions or adapt their everyday behaviour as a result of serious alarm or distress.[28]

[27] https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf
[28] Controlling or Coercive behaviour in an intimate or family relationship – Statutory Guidance Framework – Home Office December 2015 p. 3-4
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

10.2 Counter allegations (see incidents 2(a), 4(a), 4(b))

The IMR provided by Hampshire Constabulary raised the issue of counter allegations in domestic abuse cases. It is not infrequent for counter allegations to be made by perpetrators of domestic abuse[29], in fact it often forms part of the pattern of coercive and controlling behaviour[30]. Perpetrators seek to control their victims by ensuring that other agencies see the victim as a threat, and/or less plausible than themselves. In this sense when an allegation of domestic abuse is made against them it instantly renders the situation a 'six of one, half a dozen of the other' scenario and leaves the primary victim in a space where they are less likely to be believed.

During this incident the police arrested Betty, and, if this had been a standalone incident of domestic abuse, this would have been the correct course of action, given Hampshire Constabulary's pro-arrest policy and the fact that Betty admitted the offence. However, only two days previously the police had been in attendance for violence towards Betty from Paul; in the context of what we now know and the fact that Paul admitted strangling Betty but was never arrested, it is important to reflect on how Betty would have perceived this event.

We cannot possibly know what conversations Betty and Paul had about these events; however, it is within the realms of possibility to suggest that Paul would use Betty's arrest and subsequent charge to his advantage, either by labelling her as the problem or by minimising his behaviour towards her.

10.3 Police arrest of Betty

When Betty was arrested it is recorded on the body worn vest camera that she repeatedly told the police *'nobody believes me'*, although the officer was calm and kind in her approach to Betty none of these disclosures were interrogated further, either through the use of a DASH or in her interview in custody.

The stark facts are that when Paul was violent towards Betty, she called 111, which ended in a call to the ambulance service, who in turn called the police. When police did attend an arrest was not made, an inadequate DASH form was completed, and no further support or advice was offered. However only two days later, Paul accuses Betty of violence and the police respond with the full application of their policies and procedures.

A Domestic Homicide Review was undertaken into the murder of Katrina O Hara[31] on 7th January 2016 by her former partner. The first police response into domestic abuse within this relationship was made on 10th November 2015 when both parties alleged,

[29] https://safelives.org.uk/practice_blog/managing-counter-allegations
[30] https://www.researchgate.net/profile/Marianne-Hester/publication/228771295_Who_Does_What_to_Whom_Gender_and_Domestic_Violence_Perpetrators/links/02e7e518a106cb96aa000000/Who-Does-What-to-Whom-Gender-and-Domestic-Violence-Perpetrators.pdf (p.3)
[31] https://www.independent.co.uk/news/uk/crime/domestic-abuse-police-katrina-ohara-failings-dorset-phone-taken-attacker-stuart-thomas-stalking-harassment-a8148726.html

they had been assaulted and it is reported that Katrina admitted 'throwing some of the perpetrator's stuff around'. Within 58 days of making this report, the victim had been murdered. The DHR review made multiple recommendations but of note was point 6.9[32] which concluded that the first police attendance was mislabelled. Reviewing Police Officers determined that that the victim was *'very much the perpetrator'* which changed the course of police responses. It is noteworthy that this previous recommendation for another police force has been made in relation to counter allegations.

From Betty's perspective, Paul's narrative was prioritised over hers and when she made similar disclosures to the police they were treated completely differently. Perhaps that is why Betty repeatedly stated, *'nobody believes me'*, because, from her perspective, nobody did.

10.4 Sexual degradation, shaming and undermining of the victim

When reporting Betty for assault, Paul disclosed that Betty called Paul by her ex-partner's name whilst they were having sex. Paul alleged that they had subsequently started to argue, but he removed himself from the room Betty was in. The records state that Paul was *'calm and compliant'* and Betty by contrast was *'highly emotional' and 'agitated'*.

From the perspective of coercive and controlling behaviour it appears Paul expertly navigates the presentation of Betty on this occasion. Not only does Paul ensure Betty's behaviour appears unbalanced, whilst he is calm, he also plants the seed of Betty being sexually promiscuous and unfaithful. Paul thus shames and sexually degrades Betty in this exchange, leaving him as the 'wronged party' against an 'uncaring partner'.

Given what we know with the benefit of hindsight, about the ongoing image based sexual abuse and public shaming that Paul was subjecting Betty to, it is important to acknowledge that perpetrators seek to destroy a victim's reputation to isolate them from friends, family and any outside agency support networks.

It is apparent that Paul was very calculated in his presentation of both himself and Betty. Further interrogation and space for Betty to disclose and or be believed may have presented officers with a more nuanced view of the situation. Further if she had been referred to specialist independent support services, safety plans and emotional support mechanisms may have revealed that Paul was systematically abusing Betty, without her being aware of it.

In terms of coercive and controlling behaviour perpetrators undermine a victim's autonomy at every turn. The fact that Betty had twice disclosed to the police that she was intending to leave Paul was an important insight in terms of her risk[33]. When the

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[32] https://www.dorsetcouncil.gov.uk/documents/35024/289155/DHR+D5+Final+Overview+Report++January+2018.pdf/78d8e985-c5d1-22e0-5078-d2c76dfd2dff

[33] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf (P.30)

police asked Betty whether she wanted Paul to pick her up from custody, this potentially fed into the perception that even though she was saying she wanted to leave him, this was not an option for her. The author of the IMR rightly points out that Betty did consent to Paul coming to get her from custody, but it is the view of the author of this report that Betty should not have been asked this at all. Betty did have good friends and had the bail conditions rightly been applied, as noted by the author of the police IMR, it is likely she would have either found her own way home and or asked one of her friends to come and get her.

There was a series of errors in passing on the useful snippets of information Betty disclosed to the police on her arrest, and this combined with the lack of a detailed DASH form on the first reported incident, meant the potential for key disclosure opportunities from Betty were lost. The result was that the police unwittingly colluded with Paul's coercive and controlling behaviour and Betty was labelled and formally recorded as the primary perpetrator of domestic abuse. Again, reinforcing the notion that she was not believed, and Paul was.

In the context of coercive and controlling behaviour this would undoubtedly further consolidate a perpetrator's narrative that their victim was in fact the real problem and serve to further minimise the reality of the situation thus isolating the victim from support.

The panel acknowledge that since 2018 Hampshire Constabulary have now undertaken significant work to train officers in recognising coercive and controlling behaviour and review domestic cases in a multi-agency setting through scrutiny panels. It is hoped that through this investment in training police officers will be more alert to the complexities of coercive and controlling behaviour and stay vigilant to the signs of it. Further notes on training are referred to in the key findings (section 13).

10.5 Betty's friends (victim voice)

Betty's work colleagues disclosed that Paul retained control of all her wages when she initially started her job with them. They acknowledged they thought this was strange and eventually Betty did get her own bank account. Betty also had to lie to Paul about when she finished work:

> '*She lied to him [Paul] about when she finished work often. But she always kept stuff to herself although she often said she wanted to leave him, she didn't go into details, she would just say he was horrible to her. I knew that he was physically violent with her though and that he was nasty to her.' (Friend 1)*

This was information that was not shared with any other agency, no professional asked Betty in detail what was going on for her but there are key indications from the disclosure of her friends that Paul was violent and coercively controlling.

In addition to this Betty's friends were keen to point out that she was not sexually promiscuous for any other reason than that she didn't know her own self-worth. One of Betty's friends said that Betty thought:

‘sex was love, and she would do anything to be loved’ (Friend 1)

another friend stated:

‘she didn’t enjoy sex at all, she just did it because she thought that is what she had to do to be loved, and plenty of men took advantage’ (Friend 2).

These small pieces of information form a picture of a very vulnerable woman who was used and taken advantage of by the men in her life. This combined with the history of abuse she experienced as a child (discussed below 10.8), left Betty susceptible to abuse from predatory and controlling men. This was also evident from the image based sexual abuse that Paul subjected her to.

10.6 Image Based Sexual Abuse

The subsequent trial of Paul revealed that he was sending the abusive text messages and pornographic images of Betty to everyone on her contacts list. This offending went on for a period of ten months in total. Paul was calculated and strategic in his behaviour, not only did he send the messages to himself as well so that he could appear to be the victim of racial hate crime, but on the second occasion Betty reported these crimes to the police he was with her, presumably offering Betty support whilst she reported. As one of her friends noted after the trial concluded and Paul was found to be guilty the malicious communication offences:

‘*how cold and calculating do you have to be to make out that you are getting the messages too?’ (Friend 1)*

This is the epitome of power and control - research evidences:

‘perpetrators who engage in these behaviours [online sexual harms] have diverse motivations, such as revenge, building their social status, sexual gratification, control, humiliation and monetary gain.’[34].

We cannot know the motivation for Paul in committing these crimes against Betty as we were not able to ask him, and he disclosed nothing at trial that indicated his motivation. However, what we do know is that image based sexual abuse has the desired effect on the victim and causes deep psychological trauma[35], in some cases victims have died by suicide due to the shame and the effects of these types of crimes should not be underestimated.

[34] https://www.aic.gov.au/sites/default/files/2020-05/imagebased_sexual_abuse_victims_and_perpetrators.pdf
[35] https://www.birmingham.ac.uk/Documents/college-artslaw/law/research/bham-law-spotlight-IBSA.pdf

Betty's friend's perspective – Image based Sexual Abuse

> *'One afternoon we all got a pornographic video message of Betty. I deleted the others. Betty came in the next day and she said she didn't know who it was and she told us that they had been sent out to all her family, then we had to tell her that they had been sent to us as well. She was beyond mortified, she was sobbing, she thought she was going to lose us and her job. I reassured her that wouldn't happen. We told her to call the police, so she did. She got bounced about between areas. Nobody ever got back to her about these messages. They kept asking her who was it and she thought it might be one of three people but all along it was Paul. He set out to destroy her and her reputation so that the only person left would be him, so she had to depend on him.' (Friend 2)*

> *'She was so utterly broken over what he did to her on those text messages and the images that we had all seen. He sent them to everyone, everybody on her phone. Then he spent time texting us as well, saying abusive things and making it out like it was from Betty, but I reassured her that we knew it wasn't her as she didn't write like that, she would never say those things. We didn't know who it was at that point. We didn't know it was Paul.' (Friend 1)*

All Betty's friends talked about how distressed she was about these images being shared. One of her friends told of the time she came into work very upset that a fake profile had been made of her on Facebook. Betty was not on Facebook:

> *'she thought social media was evil' (Friend 2)*

Betty was desperately asking her friends how she could get the page taken down and they all tried reporting the account numerous times. At the beginning of the panel convening and in the initial stages of report writing this profile was still in existence. The profiles have now been deleted and this will be discussed further in the Key Findings section (see 13.5). The panel feel strongly that it should not be possible for a social media account to still be active after the conclusion of a trial that proved guilty of an offender. Particularly in relation to an offender who also murdered the same victim. Betty's friends were most concerned that when her name came up in media reports curious people would have searched for her on Facebook and found this account, which was open and therefore available for anyone to view. This means that Betty was still being denigrated, degraded, and sexually shamed by the same perpetrator in death, as she was in life.

It is in the power of global social media companies to resolve this issue; they should restore dignity to victims of these crimes. As Betty is not alive today to advocate for herself, the lasting public memory of her is Paul's abusive act and the panel feel

strongly this needs to be highlighted as a national issue and will be taken forward in the recommendations of this report.

Betty's friends encouraged her to report to the police but felt the way they responded was not adequate:

> *'When she phoned the police, I felt she was treated like she didn't matter. But she did matter!' (Friend 1).*

At the point of these crimes being committed against Betty by Paul, Betty could have been referred to Hampshire's independent cyber-stalking advocate. No records of this service were noted by the police and no referral was made.

We know through research from Professor Jane Monckton-Smith that presence of domestic abuse coercive control and stalking behaviours increases the risk of homicide to the victim[36]. The panel will make recommendations for the use of Professor Monckton-Smith's eight stage homicide timeline training,[37] in the multi-agency recommendations (s.14). Further recommendations have been added by the panel in relation to awareness raising for both professionals and victims with regards to technology related abuse.

10.7 Multiple and complex needs and domestic abuse

> *'She had a really mixed-up life and because of that she got pushed to one side, there was substance misuse.' (Friend 1)*

We are aware that Betty used drugs and alcohol; this featured in all the IMR reports submitted to the panel. Substance misuse in victims can increase their vulnerability and may also mask the seriousness of the violence[38] perpetrated against them. There is also an indication from the GPs IMR that Betty was also experiencing negative mental health, including anxiety and depression. The combination of these factors alongside domestic abuse resulted in Betty having multiple complex needs and the responses from agencies should have factored this in.

> *A person with 'complex needs' is someone with two or more needs affecting their physical, mental, social or financial wellbeing. Such needs typically interact with and exacerbate one another leading to individuals experiencing several problems simultaneously. These needs are often severe and/or long standing, often proving difficult to ascertain, diagnose or treat. Individuals with complex*

[36] https://eprints.glos.ac.uk/6273/1/Intimate%20Partner%20Femicide%20Timeline.pdf
https://eprints.glos.ac.uk/4553/1/NSAW%20Report%2004.17%20-%20finalsmall.pdf
[37] https://homicidetimeline.dreams-lms.com/
[38] World Health Organization (2006). 'Intimate Partner Violence and Alcohol', p1-10. Retrieved from fs_intimate.pdf (who.int)

needs are often at, or vulnerable to reaching crisis point and experience barriers to accessing services; usually requiring support from two or more services/agencies.[39]"

There are many barriers to accessing support for victims of domestic abuse but one of the key factors was highlighted by the IMR author for Hampshire Constabulary e.g. '*The reviewer is concerned that [Betty's] substance misuse may have resulted in an unconscious bias from officers and her counter-allegation may not have been appropriately considered.'*

Exclusion is a common theme for individuals, and they may find their needs labelled too complex – or too challenging – for the service they are trying to access. 'Complex' is often equated with 'difficult'. Those with complex needs are frequently considered challenging or difficult to work with whereas in reality, they challenge our *way of working*. This is a good thing[40]. The extent to which individuals are treated with dignity and respect by services will directly impact on their engagement going forward.

It is essential that all agencies understand the added barriers for victims with multiple and complex needs. The individual's presenting issues (for example, drug use, domestic abuse, mental health issues) may 'mask' other complexities (for example, childhood trauma, cognitive impairment, low levels of literacy and so on). The SCAS IMR author also noted that Betty only signed documentation with her initials which is a possible indication of low-level literacy. Individuals with complex needs often have a high level of 'hidden' disability[41]. An incomplete assessment of the individual's spectrum of needs will result in additional barriers to access and a lack of confidence that the service is able to meet the needs of the individual.

In total four out of the six incidents logged for Betty in the chronology template recorded Betty's substance misuse. Her engagement with the GPs surgery indicated a long history of substance misuse and mental health and on her arrest with the police she disclosed suffering from an eating disorder.

For victims who have complex needs not only are they often seen as problematic by agencies, but the perpetrator will use their vulnerabilities as leverage against them[42]. Paul appears to have used her vulnerability to his advantage and it is imperative to acknowledge the link in the way that perpetrators will use substance misuse or complex needs when dealing with victims and survivors of domestic abuse.

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[39] The All Party Parliamentary Group on Complex Needs and Dual Diagnosis (APPG) http://www.turning-point.co.uk/media/636823/appg_factsheet_1_-_june_2014.pdf

[40] Complex needs capable, defining complex needs, 2013, http://www.complexneedscapable.org.au/why-be-complex-needs-capable.html#defining

[41] Complex needs capable, defining complex needs, 2013, http://www.complexneedscapable.org.au/why-be-complex-needs-capable.html#defining

[42] http://www.ncdsv.org/images/WomensSubAbusewheelNOSHADING.pdf

10.8 Experiencing DA as a child

Conversations with Betty's friends revealed a complex and traumatic history of childhood domestic abuse. One of Betty's friends knew her from a young age and described the impact the abuse had on her as a child, and these descriptions were in line with current research.[43]. All her friends felt that Betty was never shown healthy and non-abusive relationships, and although Betty loved her parents dearly, because of her upbringing, she had very little self-worth.

Experiencing domestic abuse as a child often leads to lifelong trauma and health implications for victims and these can exist well into adulthood[44].

We can see from the interactions with various professionals that Betty appeared to lack self-worth. For example, her calls to SCAS were both through 111, and after clinical assessment deemed to be an emergency by professionals. The fact that Betty didn't see herself as worthy of an emergency response, but health professionals did, is telling. In addition to this she minimised the incident of domestic abuse to the police. Not only did she not dial 999 to request police assistance after the first incident (instead dialling 111 for health services), but she also underplayed the severity of the abuse. We know from her friends that they received multiple calls from Betty at different times stating Paul had attacked her. Often these would come late at night and Betty would minimise them the day after. One of the likely reasons for this was that she was used to violence from a young age and her expectations of being subjected to it were normalised. This may also have impeded Betty's ability to recognise the need for help and or feel worthy of support and investment in her as a person who was experiencing abuse.

The importance of responding to children as victims of abuse is essential as the legacy of this trauma lives on into adulthood and can have devastating consequences both in terms of psychological wellbeing and physical health. When children are supported through traumatic incidents, they are much more able to live their lives to their full potential.

This leads onto the importance of training for trauma informed practice (see Key Finding 13.1). Trauma-informed practice,[45] requires an acknowledgement of the way trauma impacts a person, not just on the way individuals see themselves and the world around them, but also on their interactions with services. A trauma informed approach starts by asking the question 'What has happened to you?' rather than 'what is wrong with you' – this would link in with Betty's experiences and her presentation, use of substances and actions of self-medicating as a way of coping. A trauma informed approach is key to ensuring individuals with a history of trauma - and in Betty's case trauma throughout the life course - feel safe in their interactions with services and aren't re-triggered by them.

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[43] https://www.womensaid.org.uk/the-survivors-handbook/children-and-domestic-abuse/

[44] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3869039/

[45] https://tce.researchinpractice.org.uk/wp-content/uploads/2020/02/Developing-and-leading-trauma-informed-practice.pdf

10.9 Routine Screening

Health based routine enquiry or "Asking the Question" of a patient whether they have experienced domestic abuse, has been researched in detail for over a decade[46]. There are many benefits to ensuring health professionals are trained to ask patients whether they are experiencing domestic abuse, and this is of particular importance for GP practices because 41% of victims attend general practices for support[47].

We can see from the IMR submitted by the GPs surgery Betty was never asked whether she was experiencing domestic abuse. The IMR author suggests that the onus and expectation should be on Betty to pro-actively seek help. The author indicates that Betty had ample opportunity to ask for help with her mental health and similarly about being subjected to domestic abuse from Paul, but this is not how routine screening works.

The chronology information and the conversations with Betty's friends provided evidence that she was seeking support for her fertility issues. In addition to this Betty asked the GP for medication for her anxiety and depression. Both these aspects of Betty's interactions with health offered opportunities for staff to explore how she was feeling, either in regard to the impact of her fertility issues on her mental health, or when she sought medication in relation to her emotional wellbeing. Opportunities like these provide health staff with a unique chance to foster disclosures when patients are experiencing domestic abuse.

It is of paramount importance for victims of domestic abuse that they are asked the question within health settings. The onus is on professionals to be curious and pro-actively ask their patients if they are suffering domestic abuse rather than waiting for them to ask for help themselves. This factor is arguably even more important when a victim has complex needs. Research shows us that the routine opportunities to ask victims whether they are experiencing domestic abuse in health-based settings yields better results. In addition, this should not be a one off as routinely 'asking' gives the message to victims and survivors that disclosing domestic abuse is acceptable and that everyone is asked therefore nobody is particularly targeted[48]. Considering there were twelve separate opportunities to ask Betty if she was being subjected to domestic abuse from Paul the panel would have expected her to be asked more than once.

It is imperative that this responsibility does not just fall to GPs surgeries. Routine screening should be universal practice for all health staff. On the first incident SCAS attended they were aware of the domestic abuse because Betty proactively disclosed it. However, the panel were concerned that there was no further exploration of the incident where Betty reported that Paul had told her she had fallen down the stairs. Genuine professional curiosity should have led the ambulance crew to gently ask

[46] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf
[47] http://irisi.org/
[48] http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf p.8

pertinent questions about whether or not Betty was being abused by Paul. Had routine screening been in place, Betty would have been asked at some point and she may have offered alternative answers or proffered information that could have led to a further safeguarding referral and or support services.

The author of the IMR for the GP's surgery (see 9.9) suggests that safeguarding alerts should be added for GPs surgeries. This can also be sent as a notification to the GP directly. However, as the panel pointed out and was picked up in the IMR from adult safeguarding (see 9.8) Betty was not subjected to a S.42 enquiry, which in essence means she did not meet the thresholds at the time. Although this threshold has been subsequently changed, there will still be other victims who will not meet a specific criterion. Therefore, relying on thresholds is no substitute for professional curiosity and a subsequent question being asked of the victim. Ultimately the latter could be the opportunity for that victim to finally meet the required threshold, but either way the onus is on each professional to do their due diligence in routine inquiry for victims of domestic abuse.

From the information provided to us under the IMR we cannot be clear whether the GPs surgery connected Betty and Paul to each other e.g., in a relationship. Given what we now know, it was the GPs surgery who had the most contact with both Betty and Paul. This was of paramount importance in the homicide review of Julia Pemberton[49], and recommendations about the importance of GPs understanding, given they may be the only agency who has the most information about both parties, were noted heavily in the Pemberton review.

In relation to Betty, health services are the key agency, she willingly reported to SCAS and phoned 111 to ask for health assistance rather than phoning the police. Betty also had twelve separate GP appointments in two years indicating she placed trust in health professionals. If routine screening had been in place there were fourteen opportunities to ask Betty if she was experiencing domestic abuse. Moreover, the nature of routine enquiry fosters a sense of openness about domestic abuse and if Betty had been asked on numerous occasions, she may have seen the importance and value of disclosing her experiences.

[49] https://aafda.org.uk/public/storage/Resource%20Items/domestic%20homicide%20reviews/Pemberton-Homicide-Review-2008.pdf

11 Equality Act 2010

11.1 The Equality Act 2010 defines the following as protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

All the protected characteristics have been considered throughout this process with mental health being addressed under 'disability'. All IMR authors were tasked with considering the protected characteristics in the support and services afforded to Betty. Services must adhere to the Public Sector Equality Duty[50] and have due regard to the protected characteristics of individuals in order to harmonise equalities and foster good relations.

There are generally three aims[51] under the PSED and these involve:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

All IMR authors considered the relevant protected characteristics and due to the fact that Betty had no formal mental health diagnosis, the relevant characteristic applied to her case is her sex.

11.2. The sex of the victim is relevant. Females are disproportionately the victims of homicide in domestic abuse cases. According to new data released by the United Nations Office on Drugs and Crime (UNODC), research shows that an average of 137 women across the world are killed by a partner or family member every day, the research further evidences that 58% of women who are murdered, are murdered by a partner or family member[52]. In addition, through the work of Karen Ingala Smith[53], we know that in the UK 1,425 women have been murdered by men over the ten-year

[50] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty
[51] https://www.equalityhumanrights.com/en/corporate-reporting/public-sector-equality-duty
[52] https://www.bbc.co.uk/news/world-46292919
[53] https://kareningalasmith.com/counting-dead-women/

period between 2009 and 2018[54]. That equates to one woman being murdered every three days by a man and one woman every four days by a man she knows. Betty shares many of the same experiences and characteristics as the other women murdered, however, the overriding factor they all have in common is their biological sex.

11.3 With respect to this DHR the conclusion is that the protected characteristic of sex should be known and understood much better by service providers and commissioners in relation to domestic abuse. The analysis and recommendations set out in the Femicide Census[55], ten-year report provide more detail.

12 Good practice

The panel noted the high calibre of the IMRs from Hampshire Constabulary, Adult Safeguarding and SCAS. The recommendations in all these IMRs were succinct and clear, and whilst a number of actions had already been initiated on submission to panel, the action plan (s.15) picks up the need to see evidence of the changes.

In addition, the panel would like to commend the police officer who showed empathy and kindness towards Betty when she was arrested and displaying distress.

13 Key findings

13.1 Multi-Agency Training

The panel felt that multi-agency training, i.e., different organisations being trained together, would be much more beneficial than siloed training programmes. This approach builds relationships amongst professionals, creates a shared ownership, and therefore provides a more cohesive knowledge of what is available when supporting both victims and perpetrators of domestic abuse.

Some of the IMR's demonstrate policy errors and omissions and lack of understanding of several key characteristics in relation to domestic abuse. There is a clear need to review the current training offer for all professionals on the issues highlighted in this report. Some of the issues raised require specialised and focused training including but not limited to:

- DASH risk assessment training
- Homicide Timeline training[56]
- Trauma informed responses including ACES[57]
- Substance misuse and complex needs training for victims of domestic abuse

[54] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf
[55] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf
[56] https://homicidetimeline.dreams-lms.com/
[57] Adverse Childhood Experiences

- Image based sexual abuse awareness
- Counter allegations

The review should include consultation with professionals on what is needed to change the culture of the response to domestic abuse. The panel felt it important to review and reflect prior to mandating further training programmes.

13.2 Routine screening

The use of routine enquiry for domestic abuse in health settings is sporadic across health services, and from the IMR records it appears that Betty was never asked the question by any health professional. The findings in this report point to a need to revisit routine enquiry for health professionals[58]. Whilst also being mindful of the intersecting needs and compounding factors of patients with complex needs.

13.3 National context

A recent series of events have placed male violence against women in the spotlight nationally since Betty's death. The Coronavirus pandemic during 2020, the murder of Sarah Everard[59] in early 2021 and the disappearance, and murder of Sabina Nessa[60] in September 2021, have led to a crescendo of calls for action and a focus from institutions on women's safety and the endemic levels of male violence against women and girls. It is worth repeating that a woman is killed every 4 days in the UK by someone she knows[61]. There is a real opportunity for a systematic overhaul by institutions and valuable reports and initiatives are now beginning to be rolled out[62].

For this impact to be felt in the city of Portsmouth it is important to consider relevant national report recommendations in a local context.

13.4 Social Media

The crimes committed against Betty by Paul via social media platforms remained available to the public nearly two years after her murder, therefore Paul's actions were, however unwittingly, being emboldened by these platforms. The chair of the review spent some time with Betty's friends, and they alerted the panel to the social media

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[58] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf
[59] https://www.bbc.co.uk/news/uk-england-london-58745581
[60] https://www.theguardian.com/uk-news/2021/sep/28/sabina-nessa-man-charged-murder-teacher-sabina-nessa-koci-selamaj
[61] https://www.femicidecensus.org/data-matters-every-woman-matters/
[62] https://www.justiceinspectorates.gov.uk/hmicfrs/publications/police-response-to-violence-against-women-and-girls/
https://www.theguardian.com/society/2021/nov/18/new-police-lead-on-violence-against-women-says-trust-has-been-broken
https://www.thetimes.co.uk/article/violent-crime-against-women-gets-the-same-status-as-terrorist-attacks-5tp2fn3pv

pages. They were very distressed that Paul was still able to publicly shame Betty in this way. As a result, the chair undertook her own research into the issue. During that research the chair linked in with the charity, Report Harmful Content[63]. This charity was finally able to get the social media pages taken down. Betty's friends had repeatedly tried to report the issue to the social media companies' long after Betty was murdered. When they were removed, they were so grateful for this.

One of Betty's friends wrote to the chair stating:

'at last she can be at peace now' (Friend 1)

Hampshire Constabulary also requested the removal of these pages on numerous occasions, but to no avail. The chair of the panel met with a Detective Chief Inspector at the constabulary to discuss the issue. Although both were supportive of the charity that was able to remove the content, the chair and the DCI agreed that it was of concern a third sector charity had been more successful in removing criminal content from the internet than a criminal justice agency.

This issue will be taken forward in the national recommendations of this report. The panel acknowledge Betty will not be the only victim this has happened to, and her loved ones will not be the only ones exasperated by the lack of interest from social media companies, when they are trying to honour her memory and dignity by taking the images down. Aside from the aspect of dignity being of paramount importance, in the starkest sense, a crime was committed, and a conviction stands for it under UK law.

There is an opportunity to link these aspects of harm of domestic abuse victims to the discussions around Online Harms Bill[64]. However, campaigners are already raising concerns that the bill does not acknowledge or explicitly name violence against women[65]. This issue will be taken up in the national recommendations section.

[63] https://reportharmfulcontent.com/?lang=en
[64] https://commonslibrary.parliament.uk/research-briefings/cbp-8743/
[65] https://www.endviolenceagainstwomen.org.uk/experts-call-online-vawg-online-safety-bill/

13.5 Betty’s friends (Victim Voice)

The last words of this report are reserved for Betty’s friends. They were asked what they thought she would have need to engage with services:

- Friend 3

‘For Betty because she was vulnerable and because she grew up with severe abuse, she didn’t even understand that abuse was not ok. She thought it was normal.

Police and her GP should have asked her more. With people like Betty there needed to be more prodding and pushing and asking of questions[66], because she would never disclose off her own back. It would have been really hard for her to say what was going on for her with Paul, but I think if they had pushed and paid attention to her more it might have been different for her.

Betty put on a tough exterior, but she was so soft underneath. It is because of what happened to Betty that I left my abusive partner, it made me realise that this could happen to me and it would have happened to me.’

- Friend 2

‘Betty might have, to some, been on the wrong path, but you couldn’t help but love her. She never had any guidance or safety. She had nobody to learn from at such a young age, she found us when she was older, and she had us. The saddest thing was that she was on the right path at the end and that is just so incredibly sad, and he took it away from her. But that is why isn’t it? Because she was getting some independence, he tried to isolate her from all of us and we weren’t going anywhere. Anyone that was around her he wanted to pull them away from her, he wanted full control of her and anyone else around her was a threat.’

- Friend 1

‘Setting her up on her own would have been good. But in all honesty, all she needed was for someone to actually listen to her. She went to the GP a lot around her fertility issues – she actually needed someone to talk to her and to actually listen to the response she gave – nobody ever asked her ‘are you ok’? I think someone completely out of her network might have just been the person that could have been her place to say how she really felt and what was going on for her. She then wouldn’t have had to put up the front for us, her work colleagues, her friends, her family.

‘I keep going back to the day I was with her when she phoned the police and she was sobbing and even I felt like grabbing the phone and shouting “will you just

[66] Professional Curiosity is paramount

listen to her", nobody was listening. Maybe that is the problem, Betty just wasn't listened too, she also wasn't ever asked.'

Following on from the recommendations received by the Home Office Quality Assurance Panel (see appendix B), the author of the review made contact with Betty's friends again to ask their views on what may have supported them to alerting her to services in order to get her support. One of Betty's friends explained that more information for family and friends would be welcome. The author has reflected this in the multi-agency recommendations and the CSP has agreed to scope the newly launched service, Findaway[67], which is specifically aimed at supporting friends and family of loved ones who are experiencing domestic abuse.

It should, however, be noted that Betty's friend further reiterated her thoughts on the findings already illuminated by the panel in this review:

> *"Knowing where to send Betty for help would have been good, but how am I meant to help her when she wasn't being offered the help herself. What is the point in me being able to get support when Betty was being ignored, I think the focus should have been on her?" (Friend 1)*

14. Recommendations

14.1 Single Agency Recommendations

There was a total of 13 single agency actions put forward by the IMR authors. These recommendations are presented below in their original format to ensure the integrity of the process. The panel have commented on each IMR recommendation and have made amendments where necessary. The final number of recommendations for the single agency action plan is 14, and the panel has suggested all single agency action plans are audited in 12 months to check they have been completed (see multi-agency recommendations 14.6).

14.1.2 South Central Ambulance Service (SCAS):

Recommendation 1: All referrals made by 111 and the emergency operations centre to be referred electronically.

Recommendation 2: Highlight through internal communications SCAS responsibility when dealing with DA incidents and the interface with police.

[67] https://www.wefindaway.org.uk/

Recommendation 3: The author recommended the use of internal reviews for SCAS teams to learn from this incident. The author suggested receiving permission from family and staff and when complete, seek authorization from an Assistant Director to cascade learning to SCAS teams.

Recommendation 4: Audits of DA Safeguarding referrals for SCAS.

The panel agree with the single agency action plan for SCAS and have confirmed where actions have been completed.

14.1.3 Hampshire Constabulary:

Recommendation 5: Hampshire Constabulary to consider review of force policy with regards to mandating a timeframe for what constitutes a non-current domestic abuse report and that the necessity for arrest/positive action can still justify an arrest in a non-current domestic abuse report.

Recommendation 6: Hampshire Constabulary to be reassured that the recording, evaluation, and investigation of counter-allegations is including in training and understood by frontline officers and staff.

Recommendation 7: Hampshire Constabulary to increase awareness amongst frontline officers and staff of the effect substance misuse can have on victims of domestic abuse, including how this can impact on their mental capacity, recollection, decision making and increased vulnerability.

Recommendation 8: Hampshire Constabulary ensure that custody staff and officers are up to date with training relating to Domestic Abuse.

Recommendation 9: Hampshire Constabulary as a part of ongoing Continuous Professional Development for custody officers and staff emphasise the significance and importance of a thorough pre-release risk assessment and that they routinely consider the impact of a domestic abuse incident for both victim and offender at point of release.

The panel agree in principle with the single agency action plan for Hampshire Constabulary, however, the panel would like to see evidence of the following moving forward:

Panel comment - Recommendation 5: Hampshire Constabulary to ensure clear internal comms are repeated after the review to ensure officers are clear of the force policy with regards to mandating a timeframe for what constitutes a non-current domestic abuse report and remind officers the arrest/positive action policy is applicable in a non-current domestic abuse report.

Panel comment - Recommendation 6: Hampshire Constabulary's crime data integrity scrutiny panel regularly check that reports of domestic abuse include

reference to any counter-allegations. Hampshire Constabulary agreed to feedback provide regular evidence from the DA scrutiny panel to the CSP in relation to Portsmouth specific DVA data.

Panel comment - Recommendation 7: The CSP would like to receive confirmation that the DA Matters training includes the impact of substance misuse in cases of domestic abuse. (see recommendation 8 below)

Panel comment - Recommendation 8: Feedback to the CSP on the effectiveness of training related to domestic abuse, including the effectiveness of SafeLives DA Matters training[68].

14.1.4 Safeguarding Adults (PCC Adult Social Care):

> **Recommendation 10:** The IMR author provided the panel with information to evidence that the policy and procedure within the Adult MASH has now changed with hindsight of this case. Practice within the MASH has moved forward and contact would be made with a person referred with the same compounding issues of substance misuse as Betty. A member of the team will call a person to discuss/agree any action needed and to offer further support services.
>
> **Recommendation 11:** Raise Awareness of the referral process for adults experiencing or at risk of Domestic Abuse. Training has been commissioned to promote Pan Hants guidance referencing raising safeguarding concerns.

The panel agree in principle with the single agency action plan for ASC, however, the panel would like to see evidence of the following moving forward:

Panel comment - Recommendation 10: Although the IMR author has confirmed that the auditing of this new process will commence in Spring of 2022, the panel will further recommend that the Portsmouth Safeguarding Adult board will take responsibility to oversee this change.

14.1.5 General Practitioners, Practice Nurses and Health Care Support staff:

> **Recommendation 12** Ensure patients who have been referred onwards for safeguarding are followed up. In this case, Betty was seen several times after her safeguarding referral without triggering concern. The administrative team to put an alert on once a letter has arrived at the surgery and a patient has been referred to the safeguarding team. Exploration of social services having access to the medical notes with patient consent.

[68] https://safelives.org.uk/training/police

Recommendation 13: Maintain low thresholds for seeing patients identified as at risk subject to a safeguarding enquiry. This can then be taken into consideration when assessing their needs and vulnerabilities.

The panel noted that with regards to Recommendation 12, social care already have access to patient records and can access them once a referral is made via the MASH process. In addition, the panel felt that the recommendations from the GP were not easy to audit and there were some further recommendations the panel felt were missing from the IMR author's submission. Therefore, the panel have rejected the original wording of the IMR author's recommendations and amended them to the following:

Recommendation 12: Primary Care to consider a review of their routine screening questionnaires to ensure it includes a question relating to the patient experiencing domestic abuse.

Recommendation 13: Review of processes/policies/training in relation to patients requiring support with drug and alcohol misuse to ensure potential safeguarding issues are considered for all GPs surgeries in Portsmouth.

Recommendation 14: In both Police and Probation services, domestic homicide reviews are dealt with by a central team whose role it is to compile IMR reports and liaise with review panels. This should be considered for health services so that professionals can retain their specialist focus where it is needed most, and future panels can receive high quality reports.

14.2 Multi-Agency Recommendations:

14.2.1 The Domestic Abuse Strategy Group will monitor a repeat audit for all single agency actions in twelve months to check all actions have been completed.

14.2.2 Universal health services revisit training and share information with health professionals regarding the importance of routine screening and asking the question of patients whether they are experiencing domestic abuse, as set out in the NICE guidelines[69].

14.2.3 Using Betty's story as a case study, Portsmouth's multi-agency domestic abuse practitioner's forum to consult with professionals on what needs to be done to change the culture within their own organisations and as coordinated partners in responding to domestic abuse. Particular attention will be given to unconscious/conscious bias

[69] https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381

with regards to Betty's case and how she presented in relation to both her multiple and complex needs and the care she was afforded.

14.2.4 Audit content and frequency of training provided to individual agencies involved in this case to ensure training includes:

- DASH risk assessment training
- Homicide Timeline training[70]
- Trauma informed responses
- Substance misuse and complex needs
- Image based sexual abuse awareness
- Counter allegations
- Professional curiosity
- Intersectionality[71]

14.2.5 The panel recommends individual agencies involved in this review consider the Femicide Census[72] recommendations in strategies and commissioning.

14.2.6 The CSP considers whether to recommend the promotion of Report Harmful Content[73] Charity for specialist commissioned services responding to domestic abuse and sexual violence.

14.2.7 The CSP to consider awareness raising campaigns with regards to technology related abuse for the general public and ensure that information on help seeking organisations is disseminated amongst professionals through training programmes and on communication portals.

14.2.8 The CSP to consider the recently launched service, Findaway[74] which supports family and friends when they are concerned about a loved one who is experiencing abuse.

14.2.9 Training to be multi-agency wherever possible to assist in making learning 'system wide'

[70] https://homicidetimeline.dreams-lms.com/

[71] https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1052&context=uclf

[72] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

[73] https://reportharmfulcontent.com/?lang=en

[74] https://www.wefindaway.org.uk/

14.3 National recommendations:

14.3.1 The panel supports the author to approach the Home Office to legislate for the removal of proven criminal content on social media platforms.

14.3.2 The panel supports the author to request government consider the recommendations within the Femicide Census in relation to the national VAWG strategy.

15. Action Plan

Recommendation	Panel Comment	Organisation	Owner	Date
Single Agency Action Plan		**South Coast Ambulance Service**		
1. All referrals made by 111 and the emergency operations centre to be referred electronically.	N/A	Southcoast Ambulance Service (SCAS)	Paul Phillips	N/A
2. Highlight through internal communications SCAS responsibility when dealing with DA incidents and the interface with police.	N/A	SCAS	Paul Phillips	31/03/2021
3. The author recommended the use of internal reviews for SCAS teams to learn from this incident. The author suggested receiving permission from family and staff and once typed seek authorisation from an Assistant Director to cascade learning to SCAS teams.	N/A	SCAS	Paul Phillips	31/05/2021
4. Audits of DA Safeguarding referrals for SCAS.	N/A	SCAS	Paul Phillips	March 2022

Recommendation	Panel Comment	Organisation	Owner	Date
		Hampshire Constabulary		
5. Hampshire Constabulary to consider review of force policy with regards to mandating a timeframe for what constitutes a non-current domestic abuse report and that the necessity for arrest/positive action can still justify an arrest in a non-current domestic abuse report.	Hampshire Constabulary to ensure clear internal comms are repeated after the review to ensure officers are clear of the force policy with regards to mandating a timeframe for what constitutes a non-current domestic abuse report and remind officers the arrest/positive action policy is applicable in a non-current domestic abuse report.	Hampshire Constabulary	Chief Superintendent David Powell	Check development of actions and begin review April/May 2022
6. Hampshire Constabulary to be reassured that the recording, evaluation, and investigation of counter-allegations is included in training and understood by frontline officers and staff.	Hampshire Constabulary's crime data integrity scrutiny panel regularly check that reports of domestic abuse include reference to any	Hampshire Constabulary	Chief Superintendent David Powell	Check development of actions and begin review April/May 2022

Recommendation	Panel Comment	Organisation	Owner	Date
	counter-allegations. Hampshire Constabulary agreed to feedback provide regular evidence from the DA scrutiny panel to the CSP in relation to Portsmouth specific DVA data.			
7. Hampshire Constabulary to increase awareness amongst frontline officers and staff of the effect substance misuse can have on victims of domestic abuse, including how this can impact on their mental capacity, recollection, decision making and increased vulnerability.	The CSP would like to receive confirmation that the DA Matters training includes the impact of substance misuse in cases of domestic abuse. (see recommendation 8 below)	Hampshire Constabulary	Chief Superintendent David Powell	May 2022
8. Hampshire Constabulary ensure that custody staff and officers are up to date with training relating to Domestic Abuse.	Feedback to the CSP on the effectiveness of training related to domestic abuse, including the effectiveness of	Hampshire Constabulary	Chief Superintendent David Powell	Feedback to CSP leads May 2022

Recommendation	Panel Comment	Organisation	Owner	Date
	SafeLives DA Matters training[75].			
9. Hampshire Constabulary as a part of ongoing Continuous Professional Development for custody officers and staff emphasise the significance and importance of a thorough pre-release risk assessment and that they routinely consider the impact of a domestic abuse incident for both victim and offender at point of release.	N/A	Hampshire Constabulary	Chief Superintendent David Powell	April 2022
		Safeguarding Adults		
10. The IMR author provided the panel with information to evidence that the policy and procedure within the Adult MASH has now changed with hindsight of this case. Practice within the MASH has moved forward and contact would be made with a person referred with the	Although the IMR author has confirmed that the auditing of this new process will commence in Spring of 2022, the panel will further recommend that the Portsmouth	Portsmouth Safeguarding Adults Board (PSAB)	David Goosey (Independent Chair)	June 2022

[75] https://safelives.org.uk/training/police

Recommendation	Panel Comment	Organisation	Owner	Date
same compounding issues of substance misuse as Betty. A member of the team will call a person to discuss/agree any action needed and to offer further support services.	Safeguarding Adult board will take responsibility to oversee this change.			
11. Raise Awareness of the referral process for adults experiencing or at risk of Domestic Abuse. Training has been commissioned to promote Pan Hants guidance referencing raising safeguarding concerns.	N/A	Adult Social Care	Rachael Roberts	March 2022
		General Practitioners, Practice Nurses and Health Care Support staff		
12. Primary Care to consider a review of their routine screening questionnaires to ensure it includes a question relating to the patient experiencing domestic abuse.	Panel recommendation	GPs – Surgeries Portsmouth	Sarah Shore	Ongoing to December 2022

Recommendation	Panel Comment	Organisation	Owner	Date
13. Review of processes/policies/training in relation to patients requiring support with drug and alcohol misuse to ensure potential safeguarding issues are considered for all GPs surgeries in Portsmouth.	Panel recommendation	GPs – Surgeries Portsmouth	Sarah Shore	April 2022
14. In both Police and Probation services, domestic homicide reviews are dealt with by a central team whose role it is to compile IMR reports and liaise with review panels. This should be considered for health services so that professionals can retain their specialist focus where it is needed most, and future panels can receive high quality reports.	Panel recommendation	Universal Health Services	Sarah Shore/ Shonagh Dillon	April 2022
Multi-Agency Action Plan				
1. The Domestic Abuse Strategy Group will monitor a repeat audit for all single agency actions in twelve months to check all actions have been completed.	N/A	CSP	Chair/CSP	December 2022

Recommendation	Panel Comment	Organisation	Owner	Date
2. Universal health services revisit training and share information to health professionals regarding the importance of routine screening and asking the question of patients whether they are experiencing domestic abuse, as set out in the NICE guidelines[76].	N/A	CSP	Jo York	May 2022
3. Using Betty's story as a case study, Portsmouth's multi-agency domestic abuse practitioner's forum to consult with professionals on what needs to be done to change the culture within their own organisations and as coordinated partners in responding to domestic abuse.	N/A	Domestic Abuse Practitioners Forum	Chair	April 2022
4. Audit content and frequency of training provided to individual agencies involved in this case to ensure training includes:	N/A	Domestic Abuse Strategy Group	Chair	October 2022

[76] https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381

Recommendation	Panel Comment	Organisation	Owner	Date
• DASH risk assessment training • Homicide Timeline training[77] • Trauma informed responses • Substance misuse and complex needs • Image based sexual abuse awareness • Counter allegations • Professional curiosity • Intersectionality[78]				
5. The panel recommends individual agencies involved in this review consider the Femicide Census[79] recommendations in strategies and commissioning.	N/A	CSP	Bruce Marr/Lisa Wills	Next Commissioning cycle
6. The CSP considers whether to recommend the promotion of Report Harmful Content[80] Charity for specialist commissioned services responding to	N/A	CSP	Chair	July 2022

[77] https://homicidetimeline.dreams-lms.com/

[78] https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1052&context=uclf

[79] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

[80] https://reportharmfulcontent.com/?lang=en

Recommendation	Panel Comment	Organisation	Owner	Date
domestic abuse and sexual violence.				
7. The CSP to consider awareness raising campaigns with regards to technology related abuse for the general public and ensure that information on help seeking organisations is disseminated amongst professionals through training programmes and on communication portals.	N/A	CSP	Bruce Marr/Lisa Wills	September 2023
8. The CSP to consider the recently launched service, Findaway[81] which supports family and friends when they are concerned about a loved one who is experiencing abuse.		CSP	Bruce Marr/Lisa Wills	September 2023
9. Training to be multi-agency wherever possible to assist in making learning 'system wide'	N/A	CSP	CSP	Ongoing
National Recommendations Action Plan				
1. The panel supports the author to approach the	N/A	CSP	Shonagh Dillon	April 2022

[81] https://www.wefindaway.org.uk/

Recommendation	Panel Comment	Organisation	Owner	Date
Home Office to legislate for the removal of proven criminal content on social media platforms.				
2. The panel supports the author to request government consider the recommendations within the Femicide Census in relation to the national VAWG strategy.	N/A	CSP	Shonagh Dillon	April 2022

16. Appendices

Appendix A

Draft Terms of Reference – Portsmouth DHR – September 2020 (Version 3)

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide and as a result change future processes and practice for potential and current victims of domestic abuse. The review will be undertaken and conducted in an open minded and consultative manner, taking into account the need to uphold confidentiality and refrain from apportioning blame. Agencies will think critically about what they could have done differently both independently of each other and in partnership.

Principles of the Review

1. The victims voice will be the central priority to the review process
2. The panel and all agencies involved will be objective, empathetic, respectful, involved and independent
3. All agencies and professionals will be open and transparent whilst safeguarding confidentiality where possible
4. Respect for equality and diversity will be paramount
5. Professional curiosity will enable questions to be asked about processes or cultures that can enable a change or uphold good practice for future and current victims and survivors of DVA.

Agencies involved / membership TBC

- Hants constabulary
- Portsmouth City Council
- National Probation Service
- Health (which Trust)?

Specific areas of enquiry

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with the parties mentioned within the IMRs from 01/01/2018 to 17/12/2019

2. Whether, in relation to the family members or friends of the victim, an improvement in communication between services might have led to a different outcome

3. Whether, in relation to the alleged perpetrator, there are any lessons to be learnt in how previous incidents of domestic violence and abuse or offending behaviour were managed.

4. Whether the work undertaken by services in this case was consistent with each organisation's professional standards and their domestic violence and abuse policy, procedures and protocols.

5. The response of the relevant agencies to any referrals relating to the victim and or the alleged perpetrator, concerning domestic violence or other significant harm from 01/01/2018 onwards until the point of the death (17/12/2019). It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

> *(b) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards.*
>
> *(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.*
>
> *(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.*
>
> *(d) The quality of the quality of needs/risk assessments undertaken by each agency in respect of both parties.*
>
> *(e) Whether there were opportunities for professionals to routinely enquire or any missed opportunities to identify if there was domestic abuse in the relationship*
>
> *(f) The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of victims.*

7. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

8. Whether practices by all agencies were sensitive to protected characteristics enshrined in the Equality Act 2010; and whether any special needs on the part of either of the adults were explored, shared appropriately and recorded.

9. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner in accordance with agency domestic abuse policy.

10. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

11. Were there any concerns amongst family / friends / colleagues or within the community and if so how could such concerns have been harnessed to enable intervention and support?

Information Sharing – Health:

Home Office Guidance states:

The Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and, where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:

a) The review team should be informed about the existence of information relevant to an inquiry in all cases; and

b) The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or partial redaction of record content.
The Department of Health is clear that, where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest.[82]

Family involvement and Confidentiality

Home Office Guidance requires that:

"members' of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim networks in the review process. Members of these support networks should be given every opportunity to contribute unless there are exceptional circumstances",

and:

"Consideration should also be given at an early stage to working with family liaison officers and Senior Investigating Officers (SIOs) involved in any related police investigation to identify any existing advocates and the position of the family in relation to coming to terms with the homicide."[83]

The review will seek to involve the family of the victim and the perpetrator in the review process, taking account of who in the victim's family wish to have involved as lead members and to identify other people they think relevant to the review process.

[82] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf (p.27 – paragraph 99)
[83] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

Communications

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this. We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by pseudonyms, this will be discussed in detail with family members.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Timescales

All Domestic Homicide Reviews are to be submitted to the Home Office within 6 months of notification. Any delays to this deadline will be communicated to the Home Office.

The Review will aim to finish by September 2021, subject to the conclusion of the Criminal Trial in February 2021

Media strategy

Any media enquiries prior to the conclusion of the trial must be referred to Hampshire Constabulary. Post-trial, enquiries should be directed to Portsmouth City Council media team who will agree a strategy with the chair and the lead officer for the CSP.

Chairing & Governance

An independent chair has been appointed to lead on all aspects of the review and will report to the Community Safety Partnership.
A Panel has been convened specifically to overlook the review process. This is a mix of statutory and voluntary sector agencies and includes specialist domestic violence expert/s.

The Portsmouth City Council Community Safety partnership, part of the Health and Wellbeing board will sign off the final report and submit it to the Home Office Quality Assurance process.

Agency roles and responsibilities

- Delegate a senior officer to lead on the review on behalf of their organisation
- Senior officers will attend all Panel meetings
- Complete Individual Management Reviews within agreed timeframes
- Contribute to the Review Report

Information Sharing & Confidentiality

The principles outlined in Portsmouth City Council Community safety partnership information sharing policy will be applied at all times. In addition to this, further reference will be made to the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

Appendix B – Home Office Quality Assurance Letter

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Lisa Wills
6 Civic Offices
Guildhall Square
Portsmouth
PO1 2AL

21 September 2022

Dear Lisa,

Thank you for submitting the Domestic Homicide Review (DHR) report (Betty) for Portsmouth Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 27th July. I apologise for the delay in responding to you.

The QA Panel felt that this was a well-structured, sympathetic and thoughtful review, with well-designed terms of reference. The analysis is supported by relevant research and evidence, identifying some key points of learning around coercive and controlling behaviour.

Condolences are offered to the family at the start of the overview report and executive summary, and a special thanks given to her friends that contributed to the report, this kept Betty front and centre. It is highlighted as good practice that the report explores barriers for victims in disclosing domestic abuse and features comprehensive and specific recommendations which address key learning points

The Panel commend the engagement of three of Betty's friends who provided details on her personality, and her life, including her desire to start a family and the attempt to engage her family. The Panel also highlights the use of learning from other cases as good practice.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for development:

- The report states Betty rang her friends multiple times to tell them that Paul was attacking her. It would be useful to consider what they might have found helpful in alerting her to the dangers and to signposting her. This could also extend to how the rest of the community could be made aware of domestic abuse and the services available.

- There is no information about how they met, nor any analysis of any previous domestic history. It is important to understand the perpetrator's behaviour and identify if any intervention could have been made previously, for future learning.

- In the report, a friend mentions that Betty went to her GP in relation to her fertility issues. It would be useful for the report to look at whether questions were raised with Betty around how she was feeling and possibly the impact the fertility struggles were having on her mental health. For example, could a disclosure for support have been made. There was also further missed opportunities when Betty asked for medication to support her with her depression and anxiety and it is unclear if there was any conversations about why Betty might need the medication.

- It would have been good for the report to explore if the threshold for the multi- agency risk assessment conference (MARAC) was met and the missed opportunities, such as a Clare's Law Disclosure (Domestic Violence Disclosure Scheme).

- It would be useful to understand whether the local panel considered approaching the taxi firm that collected Betty for work every morning, her employer or her ex- partner, Tommy.

- Further reassurance is needed in the 'Independence of Chair' section. For example, it would be useful to understand if the Author put things in place to mitigate the fact, they are the CEO of a local DA Charity.

- It would have been good to see another DA Specialist on the panel as the Chair/Author has a specific focus and a second pair of eyes may have been helpful.

- At 8.1 it would be useful to state if the family were given the Home Office leaflet and if they were informed about support available from specialist and expert advocacy services.

- There is a lack of consideration given regarding protected characteristics – this section should be expanded on.

- The action plan lacks outcomes or any narrative on what has happened

in respect of those actions that should have been completed. Further thought should be given to framing the recommendations in a way that will result in whole system improvement.

- The possibility that Betty had been subject to unconscious/conscious bias on the part of some professionals is not followed through in the proposed training. This point links to that about the ways in which perpetrators seek to shame victims in public and should form part of a system-wide learning approach. This should be addressed in future learning and recommendations.

- The report highlights that there was a missed opportunity for the police to utilise the cyber team within the force. The report goes some way to highlight the gaps in police training and makes suggestion for training on intimate image-based abuse. The report could have gone further in addressing the police response to the technology-related abuse Betty experienced. It would be helpful for the report to address the number of support methods that can be utilised.

- At 10.6 the term ‘committed’ suicide is no longer recommended. An alternative could be ‘died by suicide’.

- The date of death remains at several points throughout the report, allowing for easy identification of the victim in this case and should be removed.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Lynne Abrahams

Chair of the Home Office DHR Quality Assurance Panel