Overview Report:

Domestic Homicide Review in respect of the death of 'Ana' September 2019

AUTHOR: JAN PICKLES OBE

COMMISSIONED BY SAFE CITY PARTNERSHIP SOUTHAMPTON

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Contents

Foreword by the Chair on behalf of the Review Panel

As the Chair of this Domestic Homicide Review Panel, I would wish to add my deepest sympathies, along with those of the Panel, to Ana's family and all who have been affected by her death. I would like to thank members of the family who the Chair briefly met prior to the trial and to whose statements the review has had access to. The Review Panel has been able to understand and articulate Ana's life through these contributions, this has helped the Author and Panel members to better understand Ana's lived experience, the difficulties she faced dealing with the abuse and the problems she encountered in trying to overcome it. It is a matter of great sadness that Ana is no longer a part of the family that she loved and that loved her so much. They described Ana in a statement "Ana, you passed away too soon, to join your dog Noa. We will never forget your vitality, your happiness, or your determination to achieve your goals. You always gave the best of yourself to your family, your doggies, your dreams. The word impossible was not in your vocabulary. We will always love you and miss you."

The Review was not able to meet with Ana's colleagues to gain a full picture of her working life as her employer, a shipping company refused permission. Despite her colleagues expressing a desire and willing to meet the Chair.

Domestic Homicide Reviews serve a number of key purposes - these include learning how local professionals and organisations can work more effectively individually and together to safeguard victims of domestic abuse, thereby helping to prevent domestic abuse, violence, and homicides. We hope that this review has honoured Ana's short life.

Jan Pickles OBE Chair and Author

1 The circumstances that led to this review

This report of a Domestic Homicide Review examines agency responses and support provided to Ana, a resident of Southampton prior to the point of her murder at the home she had shared with Marc in September 2019. Ana died from twenty-three stab wounds, with four stab wounds to the heart. The weapon was a kitchen knife. Marc had stalked her during the course of the evening whilst on bail from the Magistrates court having been charged with criminal damage, malicious communication and breach of bail and remanded in custody by police and then released on bail by the Magistrates court after he pled guilty to those charges for a Pre-Sentence report to be prepared by Probation prior to sentencing. During the course of the evening before her death, Ana believed she had been followed by him into the pub and went home as she was fearful of him and was unsettled by the sensation of him watching her. She shared her concerns with the companion she was with who walked her home. Marc then followed Ana and her friend for a mile on foot as they walked to her home. Her companion left her at the front door but later intervened when he heard the signs of Ana struggling with him. After a three-week trial in February 2021 Marc was found guilty by a jury unanimously of her murder. A month later in March 2021, he was sentenced at Winchester Crown Court to a Life sentence to serve a minimum of nineteen years in Prison.

This review will consider the contact/involvement agencies had with Ana and Marc from September 2016 when we believe they both arrived in the UK. The key purpose for undertaking DHR's is to enable lessons to be learned from homicides in which a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand fully the course of events in detail in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1 Timescales

Following Ana's murder Hampshire Constabulary informed the Safe City Partnership that the murder met the criteria for a DHR. The Safe City Partnership informed the Home office and the Coroner in late October 2019 of its intention to undertake a DHR. Letters were sent to fifteen organisations (21/10/19) within the city requesting whether either of the parties were known to the agency and to secure files if this was the case.

- Community Rehabilitation Centre,
- The Hampton Trust,
- Southampton City Council (SCC) Adult Safeguarding,
- SCC IDVA Service,
- Southampton PiPPA Helpline,
- Southern Health Foundation

- SCC Housing / homelessness,
- NHS Solent
- National Probation Service
- Adult Safeguarding NHS
- Primary Care
- Change Grow Live (commissioned substance use provider)
- Yellow Door (commissioned domestic and sexual abuse provider)
- Aurora New Dawn (commissioned domestic abuse provider)
- Victim Support Hampshire

This review process commenced in November 2019 and was concluded in May 2022. This Review was delayed by the Covid-19 pandemic which also delayed the Criminal Trial until February 2021. The Pre -Sentence Report prepared for the earlier offence of Criminal Damage was seen by the Panel in April 2022. Ana was an EU National and her family live in their home country. Travel due to the Covid -19 restrictions complicated attempts to contact her parents. The Chair met with them in July 2020 when they visited the UK to meet with the Police and Crown Prosecution Service. Following advice from the Senior Investigating Officer Ana's housemate and closest friend who lived with her and witnessed the previous Criminal Damage was a key witness could not be spoken to until after the trial concluded. Several unsuccessful attempts were made to contact the family and Ana's housemate and friend following the trial which added to the delay. The full Pre-Sentence Report for the earlier offence of Criminal Damage was requested and this was received by the Panel in April 2022.

1.2 Confidentiality

The findings of this review have remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until after the report was approved by the Home Office Quality Assurance Panel. In order to protect the identity of the victim the family were asked to choose pseudonyms but did not wish to. The Panel then chose the names used in this Review.

1.3 Equality and Diversity

The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. Ana (female) identified as Spanish, with no known ongoing health issues. Ana was 28 years of age at the time of her murder. Her use and understanding of the English Language were sufficient for her to work and live in the UK. The panel acknowledges and was mindful throughout the review the inherent nature of domestic abuse being predominately female victims being killed by male current / ex-partners. There is no other information of the protected

characteristics that would indicate there were other additional barriers to her in accessing services.

In terms of Marc (male) and the Protected Characteristics within the Equality Act 2010, he identifies as of Moroccan descent but had lived in Spain as a young person, was 29 years old at the time of the murder. Medical records show Marc had a history of self-harm. Ana and Marc had known each other since childhood having come from the same small community in Spain to the UK in 2016.

1.4 Methodology

The Southampton Safe City Partnership commissioned Jan Pickles OBE to Chair and author the review. As Ana and Marc had lived in Liverpool prior to their move to Southampton the Community Safety Partnership in that area were also approached for information. The initial scoping of fifteen agencies in Liverpool and Southampton identified only two agencies had relevant information. This report is based on the Independent Management Reports (IMRs) commissioned from the agencies with information and were prepared by professionals who were independent from any involvement with the victim, her family, or the perpetrator. The authors of these IMRs have made recommendations to the Panel.

They have been signed off by a responsible officer in each organisation. The agencies' IMRs were integrated into an overarching chronology of events that led to the murder of Ana.

In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support.

In July 2020, the author met Ana's parents and cousin briefly with a translator to express our condolences and outline the DHR process. The author reviewed attending officers' body worn camera footage from an earlier incident in which Marc had caused substantial damage to their property ripping off radiators and a toilet from the walls. He was later charged and convicted of Criminal Damage. The Chair also asked to see decision making recording relating to the Custody suite and the quality assurance process of the risk assessment undertaken by the Police Safeguarding Hub.

1.5 Terms Of Reference (see Appendix 2 for Terms of Reference in full)

This Domestic Homicide Review (DHR) was commissioned by the Southampton Safe City Partnership following the murder of Ana. The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself

Domestic homicide reviews are not inquiries into how the victim died or who is culpable. In order for lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

The Victim was a Spanish National who at the time of writing these Terms of Reference was believed to have lived in the UK for three years moving from Spain to Liverpool with the perpetrator (also a Spanish National) then settling in Southampton.

The purpose of the review is to:

- Establish the facts that led to the incident in September 2019 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate.

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the perpetrator.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

Scope of the review

The review will:

Consider the period from September 2016 to September 2019 subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

- To consider the impact of the victims and perpetrators nationality on agency responses.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?

- Was the perpetrator known to domestic abuse services, was the incident a one off or were there any warning signs.

- Were there any barriers experienced by the victim or family, friends, and colleagues in reporting the abuse.

- Where there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?

- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?

- Consider any equality and diversity issues that appear pertinent to the victim, perpetrator.

- Was the perpetrator known to have a history of DA, if so, what support was offered to the perpetrator?

- Were staff working with the perpetrator confident around what service provision is available around DA locally?

- Consider any equality and diversity issues that appear pertinent to the perpetrator?

1.6 Involvement of family, friends, and work colleagues.

The review contacted the Spanish Consulate in December 2019 to share the Chair's contact details and an Advocacy After Fatal Domestic Abuse ('AAFDA') leaflet in her parent's first language explaining the DHR process and outlining support available for them in the UK. As the family lived outside of the UK, they were not eligible to receive support from the Victim Support Homicide Team, however it must be noted that the Family Liaison Officer (FLO) provided by Hampshire Constabulary provided a support service which Ana's parents noted was superior to that which they would have received at home. Prior to the trial, Hampshire Constabulary Major Crime Team in July 2020 brought Ana's parents and cousin to the UK to meet with the Crown Prosecution Service (CPS) and prepare a Victim Impact statement.

The Chair also met with them in July 2020 to explain the process and seek their help with the DHR which they generously offered. At the time they and Ana's housemate were listed as witnesses and therefore following Police advice no further information could be discussed, until the trial had concluded. At this meeting with Ana's parents, the chair offered to make arrangements for them to receive professional support in Spain or to meet with other families who had experienced the death of a loved one in similar circumstances. A Violence Against Women Service was identified which could provide support to them near to their home and the details shared with her family in a letter translated into Spanish. Ana's parents did not wish for this to happen at this point expressing the view that they could only cope with close family support at present. Ana's parents reside in a small community in which Marc's family had also lived for many years. Ana's mother told me that they were private people and that she had only recently, a year after her daughter's death been able to talk with her best friend about it.

The DHR process was paused due to Covid-19 from March to July 2020 and then by the ongoing delays to the trial during the second lockdown period in late 2020 and early 2021. In February 2021 Marc was found guilty of Ana's murder and was sentenced in Winchester Crown Court in March 2021 to life imprisonment with a minimum term of 19 years.

At the final draft stage, the Chair again offered to meet with the family at their home in Spain to discuss the content and recommendations, but they did not feel able to meet. Her parents had described Ana as an "independent woman' who cared for her family deeply, speaking with them every day as she pursued her career in the UK. She was warm, loving, and generous. A good daughter and a good friend."

The DHR panel agreed a communications strategy that sought to keep the family informed throughout the review and used both the Family Liaison Officer prior to sentence and the Chair post sentence. This was not possible as they felt unable to do so and the Panel took the view that any ongoing contact until completion of the review may be unhelpful having written on several occasions. At the initial contact the family were provided with information regarding access to advocacy and support services. The Chair and author have tried to be sensitive to their wishes, their need for privacy and support and to maintain any existing arrangements that were in place to achieve this. As the family felt unable to engage with the Review process the Chair selected the pseudonyms used in this Review.

The Chair and the IDVA Manager in Southampton arranged to meet Ana's work colleagues in Southampton after work, but they cancelled that evening, having been directed to do so by their employer.

1.7 Involvement of the Perpetrator

Following the sentencing of the Perpetrator the Chair wrote to him in prison and requested his involvement in the review, this letter was translated into his first

language, and hand delivered by the Probation staff in the prison so that any questions he had about the review process could be fully addressed. Marc chose not to co-operate with the Review.

When due to be published a copy of the executive summary will be sent to the Perpetrator in prison, and we have asked that the Probation and Prison staff provide support at that time.

2. Membership of the Review Panel

The following agencies were invited to be part of the DHR Panel. All members were representatives of their respective organisations and had had no direct or line management responsibility for services provided to Ana or Marc. The organisations and members are stated as they were at the time the review was commissioned. It is acknowledged that some organisations have undergone change since then.

Agency Representative	Role	Name
Independent Chair	Chair and Author	Jan Pickles
Domestic and sexual Abuse Service Southampton City Council	SCC Independent Domestic Violence Advisory (IDVA) Service Manager since 2006	Karen Marsh
Chief Executive and Deputy Chief Executive	The Hampton Trust	Chantal Hughes Tracey Rutherford
Domestic and sexual Abuse Service Southampton City Council	Asst Domestic and sexual Abuse Service Co-ordinator (minutes)	Kerry Owens
Hampshire Constabulary	Serious Case Reviewer	Grace Mason Bryan Carter
Southampton City Clinical Commissioning Group	Head of Safeguarding	Katherine Elsmore
Safe City Partnership, Southampton	Chair of Partnership	Mick Thompson
HM Prisons & Probation Service	Senior Probation Officer,	Jenny Mckie TJ Abrahams
Southampton City Council	Senior Policy, Partnerships Officer	Andrew Saunders
Public Health Southampton City Council	Public Health Consultant	Charlotte Mathews

Southampton City Council	District Housing Manager	Helen Prophett
Southampton City Council	Senior Commissioning Manager	Sandra Jerrim
Southampton City Council	Safeguarding Adults Team Manager	Eric Smith

2.1 Review Panel Meetings

All Panel members representing their agency had no direct contact with Ana or the perpetrator Marc. The HMPS panel member had briefly managed the PSR author who had met with Marc on one occasion. The Panel met on seven occasions, to review the IMRs and then to comment on successive drafts of the review. The initial two meetings were in person meetings and then further meetings were held virtually due to the Covid-19 travel restrictions.

2.2 Author of the Review

Jan Pickles OBE was appointed as Independent Chair of the DHR and author of this report in September 2019. She is a qualified and registered social worker with over forty years' experience of working with perpetrators and victims of Domestic Abuse, coercive control, and sexual violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of Domestic Abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she received the First Minister of Wales's Recognition Award for the establishment of services for victims of sexual violence. She has held roles as a Probation Officer, Social Worker, Social Work Manager, Assistant Police and Crime Commissioner and as a Ministerial Adviser. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

Jan Pickles is not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and has had no previous involvement or contact with the family or any of the other parties involved in the events under review.

2.3 Scoping and Individual Management Reviews

The Panel requested information from Liverpool Community Safety Partnership of any contact Ana or Marc had had with services whilst resident in their area. This inquiry produced a brief report of an admission following an incident of self-harm, he requested or received no follow up services. Of the fifteen agencies approached in the scoping exercise only two agencies Hampshire Constabulary and the National Probation Service had relevant information and were asked to submit an IMR prepared by a member of staff independent of the service delivered or of its line

management. The HMPS author had briefly managed the PSR author who had met with Marc on one occasion. Each IMR was signed by a senior person in that organisation. As Ana and Marc had lived as a couple in Liverpool contact was made with the relevant Community Safety Partnership who scoped agencies in their area for any relevant information. The only information known to them related to Marc following an incident of self-harm in 2019 having been taken by Ambulance to Hospital in Liverpool. Marc discharged himself before being assessed by Mental Health Services. We have no knowledge of whether an interpreter was employed or whether information had been translated in relation to follow up services.

2.4 Parallel Reviews

Southampton Safe City Partnership informed the coroner and the relevant agencies in September 2019 that this DHR was to take place. The coroner's inquest was permanently suspended as a result of the criminal proceedings. The Panel were not aware of any single agency reviews of this case.

2.5 Dissemination

Recipients who received copies of this report before publication are the panel members identified in 2.

Publish the findings in accordance with the Home Office Guidance to enable the lessons learned to be shared in the wider arena. It was not possible to share the final draft with Ana's parents as they did not wish to have further contact. In June 2022 the Chair again offered to meet with them at their home in Spain to incorporate into the final document any amendments prior to it being presented to the commissioning authority, Southampton Safe City Partnership but they did not wish this. Once agreed by Southampton Safe City Partnership the final draft will be sent to the Home Office for quality assurance and then published.

3. Background Information

3.1 The following background information (3.1) had been kindly provided by Ana's family, between whom there was a close and loving relationship. Ana and Marc met at High School in a small community in Southern Spain where they both lived. Ana had lived there for all her life, Marc, and his family for approximately 10 years. At the time of her murder, she was working for a shipping company and was living in a rented property in Southampton with a friend from Spain. Ana had sublet part of the property on Airbnb. Ana and Marc separated in August 2019 following an incident to which the Police were called when Marc had caused ‘substantial’ damage to the property. Ana stated to the Police that she had told Marc that their 12-year relationship was over due to his ‘volatile behaviour and heavy drinking’.

3.2 Ana was murdered by Marc her ex-partner in late September 2019 some three weeks after they had separated. Marc had stalked her, following her when she met with a person at a local pub. During their conversation she had shared she was fearful of her ex -partner Marc and so the person she had just met had walked her home. Marc had obviously followed them back to her home, again suggesting he was stalking her. Marc then immediately entered her property and attacked her with a kitchen knife striking her twenty-three times. He was pulled off Ana by the person who had walked her home who had heard the attack from outside and broke into the house in a brave attempt to save her life. Police were called and officers attended with paramedics, but sadly Ana was pronounced dead at the scene.
A post-mortem found that the cause of death was multiple stab wounds including to her neck, chest, and abdomen.

3.3 Following the murder, Marc turned the knife on himself and required treatment he was interviewed by the Police as soon as he was transferred from hospital into custody.

3.4 In February 2021 Marc was found guilty of her murder, by a jury at Winchester Crown Court. Judge Jane Miller QC when sentencing him to a Life with a minimum of 19 years in prison said: "This was a savage, ferocious and sustained attack with a knife".

4. Chronology

4.1 The following background information (4.1 – 4.4) had been kindly provided by Ana's family, between whom there was a close and loving relationship. Ana and Marc first met each other in High School in their hometown in Spain. In 2009 Ana obtained a grant to study in England for two or three weeks. When she returned home, she introduced Marc to her parents, his family lived locally also, but the families did not know each other. Ana's parents on meeting him felt him to be 'a decent and polite person.' Ana and Marc lived together in Spain for 2 years. Then Ana went to Lyon, France for a few months working in a hotel, Marc stayed in Spain. In 2018 Ana returned to the UK with Marc, initially living, and working in Liverpool, both worked for a shipping company.

4.2 In February 2019 Ana returned home to her parents in Spain as she believed Marc had been unfaithful to her, this was a surprise to her parents, they stated that they believed Marc to be a 'decent and polite partner' for their daughter. Marc remained in Liverpool where in April 2019 he self-harmed by drinking bleach and taking paracetamol. Marc had rung his family in Spain, and they alerted the Police in Liverpool. He was taken by Ambulance to Hospital but discharged himself prior to the routine Psychiatric assessment. Marc then returned from Liverpool to his parents' home near to Ana and her family. Initially Ana according to her family responded by trying to avoid him, visiting a friend in another part of Spain. It is believed however, that the couple reconciled some time following Marc's return to Spain but the exact status of their relationship in this period is not known.

4.3 Ana and Marc then returned to the UK together in 2019 staying in London in June 2019 and then moving to Southampton, sharing the same accommodation, although we are told they had not at this point resumed their relationship. Ana and Marc at some date in July 2019 initially rented a room in house when they first arrived in Southampton, later moving into the rented house in which Ana was killed. A friend of Ana's from Spain was also living at the property. In addition, it is known that Ana sub-let part of the accommodation via 'Airbnb.' There is no information relating to this arrangement other than a Police report of Ana alleging theft of money by two guests sometime in late August 2019. At some unknown point either prior to or following their return to Southampton Ana and Marc resumed their relationship.

4.4 It is known that they chose Southampton to move to because Marc had a degree in 'International Markets' and had worked in logistics and they thought that Southampton as a port city would provide the best employment opportunities for him. Ana worked initially in a restaurant, and in July 2019 finding employment at a call centre for a commercial cruise company, according to her parents she was pleased with this role.

4.5 There is no further information held by agencies concerning the two until late August 2019 when Marc was arrested by Hampshire Constabulary Officers on

suspicion of driving under the influence of alcohol. He was processed and found to be over the legal limit to drive, charged and later sentenced at Southampton Magistrates Court to a driving disqualification and fine.

4.6 The next day in late August 2019, Police Officers attended the property of Ana and Marc following a 999 call from Ana's housemate. Police Officers observed the damage to the furniture, fixtures, and fittings in the property which they described as 'substantial.' Ana stated to the officer completing the DASH that after asking him to leave as she wanted to end the relationship due to 'his drinking and volatile behaviour, Marc had begun to smash Ana's belongings and the property. Ana's flatmate stated that he had 'systematically destroyed it '. His actions were described as 'frenzied' in which he ripped radiators and a toilet from the walls, threw furniture and fittings from the upstairs windows and 'destroyed everything' in the property. The Chair of this Review has viewed the body worn camera footage from attending Police Officers which shows the extreme nature of the damage and the arrest of Marc for Criminal Damage. Despite this extreme behaviour, at the time of the arrest he presented as calm and compliant at the scene and was well managed by the attending Officers. At the time of his arrest, Ana and her friend could be seen on the pavement outside by police, 'obviously fearful for their safety.' Police reports state that Ana described his drinking and general behaviour becoming worse and that he was becoming increasingly 'volatile.' She also stated she believed that 'he was taking crack Cocaine as she had seen some white powder in his car'. During the incident it is reported that Ana sustained a bruise to her leg, and that her arm was also bruised. As the tenant Ana would have been responsible for the damage to the property to some extent such as a loss of her deposit, the motivation for the extensive damage may have been to cause her financial harm, this was never established as it was superseded by her death.

4.7 The Hampshire Constabulary IMR states that "Ana's housemate said to the Officer that she was worried that Marc would harass Ana as this is what he had done previously when they had separated. There is no record within Hampshire Constabulary of these previous separations and no further mention of them on the Record Management System (*RMS*) logs." This information does not seem to have been explored further by the Officers attending. The Hampshire Constabulary IMR notes that the attending officer had recorded in a 'lengthy' Officer's observations section that the victims had told the Officer that Marc's "behaviour is getting worse, he is getting drunk and generally being more volatile." The victim had 'told him the relationship is over and asked him to leave. This caused him to go into a rage…. He had damaged her phone so that she was only able to be contacted by her flatmate."

A statement was taken, and a DASH [1] Public Protection Notice form (PPN1) was completed. Ana answered a positive response to six of the questions asked and was accordingly assessed as at 'Standard Risk' by the DASH. The Hampshire Constabulary IMR author notes that Force Procedure defines 'Standard Risk' as 'Current evidence does not indicate a likelihood of causing serious harm.' The IMR from Hampshire Constabulary states that a Domestic Violence Prevention Notice[2] (DVPN) was considered but not actioned as there was no previous history of Domestic Abuse, "Marc had been excluded from the property by Ana and he was stating his intention to leave the country on a pre-booked plane ticket in the coming weeks." And due to the 'Standard Risk' rating of the PPN1.

4.8 A standard PPN1 was submitted to Victim Support, the following day in August 2019, as per the Hampshire Referral Pathway for Standard Risk PPN1's, Victim Support confirmed they had no contact with Ana. This PPN1 was also shared with Southampton Police Safeguarding Coordinators at the Hub (referred to locally as the MASH but not a multi-agency arrangement as in other areas) for quality Assurance purposes, as is required practice. The Hampshire Constabulary IMR states that "On the PPN1 form the Police Safeguarding Coordinators reviewed the DASH and applied a Standard risk grading. The justification section states simply '6 yes answers on the PPN. 0 previous incidents within the last 3 months." Effectively accepting the attending officer's judgement in terms of their Risk rating.

4.9 Marc was arrested and held in Police custody. The IMR from Hampshire Constabulary notes that "despite the statement of complaint being taken that evening from the victim, and Marc being in Police Custody, no attempt was made to arrange an interpreter for the interview of Marc until the following morning, by which time there was no possibility of arranging their attendance, completing an interview, and

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[1] Most forces use the Domestic Abuse, Stalking, Harassment and Honour-Based Violence risk identification, assessment, and management model (DASH). DASH is also used by partner agencies, providing a consistent approach https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/risk-and-vulnerability/

[2] 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.
A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support, they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.

seeking charging advice from the Crown Prosecution Service within the initial 24-hour custody timeframe (of the total 96 hours) allowed by Police and Criminal Evidence Act 1984 (PACE) and a Superintendent was not approached to extend this time period to 36 hours. As a consequence, the decision was taken to Bail Marc with conditions and to return to the Police Station two days later in late August 2019 for interview, when an interpreter would be available. The conditions of Bail were not to contact Ana directly or indirectly and not to attend *the home* where she lived, and Marc had caused the damage." This delay in processing Marc meant that Officers had to release Marc at this point without charge.

4.10 In line with standard procedure the Officer in the case attempted to contact Ana to inform her that Marc was to be released. However, at the time of release the Officer had not been able to contact her directly, so in line with Force protocol, instead sent a text to her and arranged for a hand delivered letter to be taken to Ana's address with details of the bail process. He also alerted the local police neighbourhood team to the situation. The Hampshire Constabulary IMR author has noted that although there are prompts to do so, the release decision making process did not lead to any further evaluation of the risks presented in terms of Ana's safety following Marc's release.

4.11 At some point in late August 2019, the Panel do not know whether before or after the offence of Criminal damage, it is reported that Ana's sister had told her parents that Marc had been arrested by the Police and that he wanted Ana to 'drop' the charges against him, this was not reported to the Police. It is reported that Ana had told her parents about his drinking, the driving offence, and that she had ended the relationship with him, just before he had damaged the house. At this point, Ana was reported to be ringing her parents daily due to her fear of him. Her parents stated they believe Ana was reassured by the Bail conditions (which they described as a 'Restraining Order') then in place, despite Marc continuing to attempt to contact her. Her parents stated that Ana did not want to return to Spain as she was enjoying her job. Ana had not told her mother that Marc had threatened her, and they believed that Ana was not afraid of him. The Panel are aware that Ana made a request to her line manager to work from home i.e., Spain but she had not completed the six months required to allow this request to be considered.

4.12 The Panel note that Hampshire Constabulary IMR author states that there appears to be no safeguarding review or summary, at any later stage in the investigation, within the RMS records after the completion of the PPN form. There is

also no evidence that the College of Policing Authorised Police Practice (APP)[3] on pre-release considerations was used by the Officer in the case or anyone else involved in the process; this would particularly have focussed on updating the risk assessment and conducting further safety planning with the victim.

4.13 The next day, in late August 2019, the Police received a message that Marc had breached his Bail conditions. He was reported to have been seen by Ana and her flatmate entering the road in which they lived. As a result, Ana and her flat mate arranged to move into a City Centre hotel which they felt would provide more safety for them. Later that day Police Officers attended the hotel they were staying at and felt satisfied that it provided Ana and her flatmate with sufficient safety and that no further action was required from them. The decision was taken not to find and arrest Marc in response to this breach of Bail due to procedural concerns concerning PACE timelines, but to charge, arrest and interview Marc and seek his remand in custody when he answered Bail at the Police station as required two days later.

4.14 At 9.30 the next day in late August 2019 Ana reported to the Police that overnight she had received three emails from Marc, one of which was abusive calling her a ‘whore’. This was recorded as a ‘Malicious Communications Offence’ and a Breach of Marc’s Bail conditions. The Hampshire Constabulary IMR author believes that it was also decided to address this further offence and the earlier Breach of Bail when Marc returned to the police station to answer his Bail the following day. The Hampshire Constabulary IMR author notes that “There was no reassessment of risk, but that the immediate safeguarding measures discussed before still applied, that Ana and her friend were staying in a hotel that Marc did not know about.” The decision was made to arrest, interview Marc in relation to all matters when he answered Bail the following day in late August 2019 and to seek a remand in custody at Court.

4.15 Marc attended the Police Station to answer his police bail as required at the end of August and was subsequently charged with Criminal Damage (£3,000 value) to the house/contents and Malicious Communication in relation to Ana (this relates to Marc breaching his police bail conditions to not contact Ana by sending her an abusive email). He was also charged with criminal damage to a car in the street committed at the same time as the damage connected to Ana.

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[3] College of Policing Authorised Police Practice https://www.app.college.police.uk/app-content/detention-and-custody-2/response-arrest-and-detention/

Once charged he was refused bail by the police and an application was made to the court for him to be remanded in custody.

He was kept in custody by police overnight and placed before Southampton Magistrates Court the following day where he pleaded guilty to the offences he was charged with. A Pre-Sentence Report[4](PSR) was requested and case adjourned for three and a half weeks until late September 2019 for sentencing.

The breach of his police bail was not a specific chargeable offence but was used as part of the police remand application to the Magistrates to demonstrate his inability to comply with bail conditions.

The remand in custody was not agreed by the Magistrates and he was released on Conditional Bail with the following Conditions:

i) Not to contact directly or indirectly Ana.
ii) Not to enter Ana's Street in Southampton except on one occasion when in the presence of a Police Officer to collect his belongings.
iii) To live and sleep each night at a certain address in Southampton.

4.16 Marc attended his interview for the PSR as required an Interpreter was provided. The IMR from the Probation Service has provided the 'Short Format' PSR prepared for Marc's sentencing to the Panel. The Panel would note that the PSR states that the defendant "displayed aggressive, controlling and risk-taking behaviour," and that a Spousal Assault Risk Assessment (SARA) a specific Domestic Abuse checklist was used which identified him as a moderate risk- which indicates that some risk factors were identified. Despite this there is no mention of the offence being considered as one of domestic abuse in the PSR and the offending behaviour and impact considered in the light of that. Added to this there is within the PSR information that suggests dynamic risk factors to be active- a recent further offence, the ongoing mental health concerns, suicidal thinking, and an inability to access treatment in terms of Marc and the recent separation in terms of the victim

[4] HM Prison &Probation Service, Determining Pre-Sentence Reports 2016. (Revised 26.6.2021) The purpose of a pre-sentence report (PSR) is to facilitate the administration of justice, to reduce an offender's likelihood of re-offending and to protect the public and/or victim(s) from further harm. A PSR does this by assisting the court to determine the most suitable method of sentencing an offender (Sentencing Act 2020, section 31). To achieve this, the Probation Service provides an expert assessment of the nature and causes of the offender's behaviour, the risk the offender poses and to whom, as well as an independent recommendation of the option(s) available to the court when making a sentencing determination for the offender. National report templates are used for reports completed.

which were not identified as such to the Court and may have been overridden by the low ‘actuarial’ scores of the RSR (Risk of Serious Recidivism) and OGRS(Offender Group Reconviction Score) in terms of assessing risk to his ex-partner.

4.17 The PSR could have been more targeted than it was in identifying and addressing the issue of domestic abuse. The report author did propose a restrictive condition, the Restraining Order, but there were no other measures included in the PSR which may have addressed the perpetrator’s abusive thinking including coercive and controlling behaviour and any economic abuse, which the Panel believe would have also helped to reduce the risk he presented to Ana and others. The Report author did identify the issue of Marc’s poor mental health and substance misuse and his difficulty in accessing treatment for that, but there was no reference to the need or means of his accessing treatment as a further means of protecting the victim.

4.18 The court appearance to answer those charges was superseded by the murder of Ana and Marc’s further remand in custody in relation to that charge. Whilst this report did not affect the tragic death of Ana it does provide an opportunity to consider assessment and report writing practice in relation to cases of domestic abuse and in particular the need to protect the victim from the perpetrator by restrictive and protective measures relating to the perpetrator.

4.19 Marc appeared at Southampton Magistrates Court in mid-September 2019 and was fined in relation to the drink driving charges. The day after Marc’s Court appearance, Ana informed her line manager at a planned supervision meeting that she had been in an abusive relationship with a long-term boyfriend. Ana was tearful and confided that there were occasions when she had to come into work slightly late (although she was never actually late) because she was worried about her walk to work on her own. At this meeting Ana made a request to work from her home in Spain and shared that she was considering resigning due to the behaviour of her ex-partner. Ana showed her manager a video of the damage caused by her partner to her home shortly after this conversation with both her line manager and two other senior managers, who noted “She seemed emotional but holding herself together well almost all cried out.” She was described by a senior manager as reassured by the ‘Restraining Order’ (*this was in fact a Bail condition)*. Ana had disclosed the damage to her home by Marc to two Spanish colleagues, one thought that Ana believed her ex-partner to be in Morocco, the other that she believed him to be still in the area as Ana told her she had seen his car in the area.

4.20 In late September 2019, Ana was attacked by her ex-partner Marc with a kitchen knife in her home and pronounced dead by the attending South Central Ambulance Service at the scene. Ana had been on a date in Southampton with another Spanish national. Ana’s date later said that Ana believed she had seen Marc at the pub earlier that evening. CCTV played at the trial showed that he followed Ana

into her home, and that Ana’s date waited outside as he was concerned for her. He then bravely forced entry when he heard shouting and screams inside the house. He stated that he saw Marc on top of Ana, stabbing her repeatedly with a knife.

5. Overview

5.1 The only Southampton agencies involved with knowledge of the victim and the perpetrator were Hampshire Constabulary and the National Probation Service who interviewed Marc for the preparation of a Pre-Sentence Report two days before the murder in September 2019. Of those, Hampshire Constabulary had most contact and knowledge of Ana.

5.2 Hampshire Constabulary's first contact with Ana was following a callout to her home in response to her partner, Marc's violent behaviour at the end of August 2019. Records show that they responded quickly and appropriately to the report of damage being carried out by Marc. They interviewed both victims separately and away from Marc. Ana was not known to the Police at that point, Marc was known as he had been arrested the day before in connection with a Drink Driving charge. That Ana complained of sustaining bruises to her leg and arm, whether these were the result of deliberate acts of violence or were accidental was not established, there is no indication Ana was asked about these injuries. Ana's flatmate also told the attending Officers that she was concerned about Marc further harassing them as he had done previously when the couple had separated. In addition, Ana told the attending Officer that she believed him to be using drugs as well as alcohol, she claimed she had seen Cocaine in his car, that she felt he was volatile and that his behaviour had been deteriorating. She also informed the attending Officers that his behaviour was the result of her attempting to separate from him. Officers completed a DASH form that was quality assured and agreed by the Police Safeguarding Coordinators as is standard procedure. The risk was assessed as 'Standard' that is not currently at risk of serious harm. The Hampshire Police IMR author stated that domestic incidents assessed as 'Standard Risk' elicited no direct support to the victim at this time other than could be offered by the attending/investigating officer at the time. The author stated, "Had Ana received a 'Medium' rating of risk she could have had more follow up support."

5.3 After his arrest in late August 2019 Police records indicate that Marc informed Officers that he was a Spanish citizen and that he was going to return to Spain in the "coming weeks," and that he had "pre- booked plane tickets." It does not seem that the Police knew of the exact date of the departure nor that they had asked to see confirmation of this booking.

5.4 Following Marc's arrest for the Malicious Communications Offence in late August 2019 (his second breach of his Police Bail conditions) the Hampshire Constabulary IMR author felt that "increased risk was apparently identified by the officer dealing (with the case), reflected by the swift arrest, charge and remand for court, but that there was no formal re-assessment of that risk, nor was any contingency put in place for the eventuality were he not remanded in custody." The author further notes that "Marc had committed another offence towards Ana, where the circumstances were

personal in nature and arising out of their domestic circumstances, no formal re-assessment of risk was made and no further PPN1 was submitted. It should have been". It seems that the increased statistical risk of harm known to be caused by separation was not considered in completing the DASH, nor the following review. This is despite the victim and her friend referencing at the incident to attending officers their fear of the perpetrator increasing as a result of the separation.

5.5 As Marc was subject to other enforceable restrictions such as Police or Court Bail it was deemed unnecessary to apply for a DVPN or DVPO[5]. It was recognised by the IMR from Hampshire constabulary that there were three key factors-

I. The DASH was (wrongly) scored as 'Standard Risk'.
II. The couple had separated (itself a risk factor that should have been considered to have increased not reduced risk to the victim).
III. that the perpetrator had 'booked' tickets for his return to Spain.

6. Analysis

6.1 The first contact that any services had with Ana as far as can be established was the 999-call made to the Police by her flatmate in late August 2019. Police Officers responded promptly, in just under 20 minutes to the call. Correct procedure was followed, the arrest of the perpetrator and interviewing the two victims of the Criminal Damage separately. The offence was correctly viewed as Domestic Abuse- a DASH and a PPN1 was completed. The DASH was also forwarded onto the Police Safeguarding Coordinators for quality assurance, and the assessment reviewed in line with service protocol. It was noted by the attending officers that the damage was 'substantial,' and that Ana had sustained bruising to her knee and her arm. Ana could not remember how they occurred, but it was believed to have been within the time of the incident. Both Ana and her friend voiced fear of the perpetrator should he be released.

6.2 In breaking down the response of the Police Officers to this incident, and subsequent event there are a number of running threads. In this the Panel are grateful for the work of the Hampshire Constabulary IMR author. Firstly, although a PPN and DASH were completed, many of the features of abusive behaviour which

[5] 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 See section 2 .4 The DVPN / DVPO process does not aim to replace the criminal justice system in respect of charge and bail of a perpetrator. A DVPN will be issued in circumstances where no other enforceable restrictions can be placed upon the perpetrator. It is important that there is no conflict between any bail conditions and the terms of a DVPN.

the Panel feel to have been present were not identified and consequently the level of risk, we believe underestimated. A DASH was completed as stated above but the risk was wrongly assessed as ‘Standard’ rather than ‘Medium,’ based on the extreme nature of the damage to the entire property and the degree of force/anger required to rip out a toilet and radiators and to smash up all furniture into no more than broken pieces of wood. This coupled with level of fear expressed by Ana and her housemate in the Body Worn Camera footage, who described them both being fearful of him after previous separations. This essentially meant no follow-on support would be offered or provided as it would have been with a medium assessment. The Panel cannot say of course if Ana would have taken up the support offered.

6.3 The Hampshire Constabulary IMR author has seen the PPN1 which forms part of the DASH and the author’s observations of that suggest a disconnect between evidence at the scene available to attending Officers and the assessment itself. In particular, although the damage to the property was recorded as ‘substantial’, and both Marc’s partner and her flatmate were clearly distressed, and both spoken of their fear of Marc returning and Ana’s flatmate had told the officer that Marc had previously harassed Ana and she feared he would do it again, the Officer answered ‘No’ to the Domestic Abuse, stalking and Harassment question and all the following questions in the ‘Domestic Abuse’ section of the DASH. Ana was also classified as an ‘ex-partner’ thus diminishing the issue of separation, masking the fact that the victim telling the perpetrator of her wish to separate was the direct cause of the offence. The Officer completing the form also identified aggravating factors on the form, Ana’s arm and leg being bruised, Marc’s substance misuse, depression, and previous suicide attempts and that his behaviour was deteriorating. The completing officer also added to the DASH that Ana was “hugely concerned about what will happen when he is released, fearing he will start harassing her.” Critically the increase in potential risk to both victims caused by the separation of victim and perpetrator was not recognised by either the officers at the scene completing the DASH, nor the reviewing officer later. This despite the increase in fear of the victims of Marc expressed to attending officers at the scene as a result of the separation. Dr Jane Monckton-Smith’s research identifies the patterns of escalating risk in domestic abusive relationships following separation.[6] This research was subsequently introduced to Southampton by Dr Jane Monckton Smith at a conference held in November 2019. Prior to this and at the time of Ana’s death this important research would not have been filtered to front line officers.

[6] Monckton Smith, J. (2020). Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide. Violence Against Women, 26(11), 1267–1285. https://doi.org/10.1177/1077801219863876 See also Jane Monkton-Smith https://www.youtube.com/watch?v=lPF_p3ZwLh8

6.4 These aggravating factors do not seem to have been considered by the Officer completing the PPN/DASH, which the Panel understand was completed later and by a different Officer. The Panel believe that the Officer was influenced in this by the answers provided by the victim to the DASH rather than the attending Officer's judgement, and as the Hampshire Constabulary IMR author believed "by the numbers alone" and not the trigger factors such as the level of fear and damage that they could see or, the issue of separation they had been told of. This would have required officers to employ their judgement based on what they had seen and heard as well as the victim's statements to them. It seems that the answers from the victim in completing the DASH ran counter to that judgement and then overruled it, leading them and later the Police Safeguarding Coordinators Quality Assurance process to conclude 'Standard Risk.' The Hampshire Constabulary IMR author also felt that the assessing officer wrongly saw the issue of separation as a protective factor in this case having been told that the perpetrator was planning to return to Spain soon which may have falsely reassured them. In this it seems that the level of damage to the house and the obvious fear held by the victims of Marc returning was somehow diminished in terms of considering the risk posed to them by Marc.

6.5 The Hampshire Constabulary IMR author reviewing this case believes that risk should have been assessed as 'Medium,' rather than 'Standard' and that one of the key reasons for this not being done may have been that the officer completing the form was not the same Officer that attended the scene and did not witness either the scale of the damage caused or seen and heard the fear held by the victims of Marc. In the opinion of the Chair of the Review the body worn camera footage clearly identified that this was an extreme event that would incur fear of the perpetrator. The IMR author stated that they had spoken to the Officer concerned and that "his principal reasons for classifying the grading as standard were that Ana had stated that she was not in fear and that there were no previous recorded domestic incidents between the couple. (However, the Body Worn Camera footage showed her and her housemate as looking fearful during the Criminal Damage offence.) He confirmed that he did understand that recent separation of a couple was a factor that had the potential to raise risk. It should also be noted that this officer did not attend the original incident and therefore did not have first-hand knowledge of the degree of damage caused to the property – which was substantial and could be viewed as an indicator of higher risk in itself." The Panel would add they were also likely to be unaware of the emotional impact on Ana and her housemate of the offence. The Hampshire Constabulary IMR author states that the 'Standard' risk assessment rating is identified within Hampshire Constabulary's 'Standard Operating Procedure' as reserved for 'Where no indicators are present.' This should not in the view of the Panel have applied in this case.

6.6 The assessment was then signed off by the Police Safeguarding Coordinators This process is mandated in standard operating procedures to confirm grading and assessment to a common matrix. It is acknowledged within the guidelines that “This will include the use of professional judgement.” The reasons given in the sign off stated ‘6 yes answers on the PPN. 0 previous incidents within the last 3 months. The Hampshire Constabulary IMR author reviewing the case spoke to the Police Safeguarding Coordinator after they had reviewed their notes and reaffirmed their view it was correct, as the Hampshire Constabulary IMR author summarised due to “the lack of any previous domestic violence history involving the couple on RMS and the fact that the violence offered was against property and not against the individual despite Officers completing a DASH. The coordinator acknowledged that Ana had sustained a bruise during the incident but stated that they considered this very minor and that there was no suggestion that it was caused intentionally by the perpetrator. The coordinator added that they did not consider that the amount of damage was a factor in assessing the level of risk. The coordinator recognised that recent separation of a couple was a potential aggravating factor and an indicator capable of raising the level of risk but stated that in this case the domestic incident occurred apparently spontaneously, directly after the separation, and therefore did not consider it as such.” This assessment is flawed in the view of the Panel and ignored several aggravating factors known at the time these are, the recent separation, resented by the perpetrator, excessive use of force suggesting the intention to intimidate and cause fear, the concern and fear expressed by the victims of the perpetrator returning and history of previous harassment, a deteriorating trajectory of behaviour, mental health, and alleged Cocaine misuse. This information was known at the time to the coordinator and is not a case of hindsight bias being applied. Using this information to develop an assessment requires professional judgement to be applied by the Officer as the victim was answering in the negative to many of the questions concerning violence, fear, and separation. It seems the victim’s answers overrode the evidence the officers gathered at the scene. The clearest indicator of this is that the offence was identified as ‘Criminal Damage’ and not the ‘Domestic Abuse’ it was. The Home Office Counting rules for crimes dictate how offences should be recorded but a DASH was undertaken therefore this suggests this was recognised as Domestic Abuse and this knowledge should have informed decisions following his arrest and the lens through which his breach of bail offences committed after his release were viewed. There is no record of whether Coercive and Controlling Behaviour was considered, to evidence an offence of Coercive and

Controlling Behaviour [7] requires ‘a pattern of behaviour’ and evidence of a ‘serious effect’ on the victim. Ana’s friend had already shared a history of previous harassment by Marc with Officers, and both were witnessed as being visibly fearful on the street during the actual offence. As noted by the Hampshire Constabulary IMR author “Professional judgement of all of the information on the DASH assessment should, in the author’s view, have meant that this case was graded higher than Standard.”

6.7 The Panel note that although working in the UK, English was Ana’s second language and that her responses to these sensitive questions at the scene when she and her housemate were clearly shocked and fearful could have been compromised by her use of English. It is possible that this may have affected her responses to the questions, this was not considered.

6.8 After Marc was arrested and taken into custody time was lost which had consequences later for managing Marc and safeguarding Ana and her housemate. Marc was arrested and held in custody after the offence. Although statements had been obtained from the victims, nothing was done in terms of processing Marc until the following morning when it was realised an interpreter was needed. This meant that Marc had to be released due to PACE timelines without being formally charged with the offence and had to be released on Conditional Bail, to return in two days’ time.

6.9 The following day after release Marc was seen by Ana and her housemate entering the road on which they lived, prohibited by the Bail Conditions set and they informed the Police. They saw him on their way to a city centre hotel which they had booked for two days as the property was uninhabitable. However, because an interpreter had not been arranged in time following the Criminal Damage arrest Marc had not been charged in relation to that offence, prior to his release, the Police could not arrest or charge him because this would have impacted on the PACE timeline. the Police must be “expeditious and keep the suspect detained no longer than is necessary.” This meant that a further risk assessment was not triggered, and the Breach of Bail was not able to be factored in as an aggravating factor. Had it been it

[7] https://www.cps.gov.uk/crime-info/domestic-abuse ‘Controlling or Coercive behaviour’ describes behaviour occurring within a current or former intimate or family relationship which causes someone to fear that violence will be used against them on more than one occasion or causes them serious alarm or distress that substantially affects their day-to-day activities. It involves a pattern of behaviour or incidents that enable a person to exert power or control over another, such as isolating a partner from their friends and family etc.
Coercive behaviour is an act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.’

could have led to a revision of the ‘Standard Risk’ assessment and more protective measures being offered to the victims.

6.10 The next day Marc sent three emails to Ana, one of which was threatening and abusive, and Marc was arrested and charged with that offence in addition to the earlier offences of the two previous days, when he attended the Police Station to answer Police Bail. Police Officers did not review the risk of harm that Marc posed to Ana on the PPN1 in the light either of the two later offences. The Police IMR author acknowledged that had a review been done it would likely have led to the revision of Ana’s risk, which may have been amended to ‘Medium’, providing the opportunity to access additional support and monitoring. As stated earlier the Panel do not know if Ana would have taken up the offer of help, but the offer should in the Panel’s view have been made. The Hampshire Constabulary IMR author notes that the Officer who was allocated to the case, was a student Police Officer and noted that he was aware of the original risk assessment conducted by *the other* Officer and ratified by the Police Safeguarding Coordinators, but he did not review it or add to it as the investigation progressed and as further risk became apparent. Risk should be viewed as dynamic and risk assessment needs to be a continuous process throughout an investigation. It is also notable from the Niche Occurrence Enquiry Log (OEL) that there was no recorded supervisory input in the case which directed him that he should do so. Force Policy states that it is the responsibility of the officer in the case to continually review risk and safeguarding measures.” Finally, following the perpetrator's second breach of Police bail, Marc was arrested and charged, and appeared in court on the 28th of August having sent Ana abusive emails designed to coerce and control her. Following Marc’s guilty plea at this hearing, Hampshire Constabulary's application for his remand in custody was not accepted by the court. Marc was released on conditional bail (Court). This appears with the value of hindsight to have been a critical moment, as the murder took place only three weeks later.

6.11 In summary there is evidence of a chain of events in which the understanding of the impact of Marc’s behaviour and the fear that Ana and her housemate had of him was lost when the PPN and DASH were completed. This seems to have been due to the responses made by Ana to the questions asked of her in completing the DASH weighing more heavily than the other evidence available to the officers at the scene. This initial error was compounded by the failure of the quality assurance process to correct or question the initial assessment and instead to confirm it. Further opportunities to reassess the original assessment were missed due in the first instance perhaps due to the inexperience of the student Police Officer, and the lack of oversight by a more experienced Officer of their practice, and the focus on ensuring actions were consistent with PACE timelines. Finally, the courts rejection of the application by Hampshire Constabulary to further remand the perpetrator in custody, was given the events that followed a critical one.

6.12 It is of note that in the case of Ana, interpreters were not used, and there was no evidence that they were considered to be needed or offered to Ana. This may have been due to the assumption that her spoken English was adequate to enable her understanding, This is a concern as it indicates a) a lack of recognition of the impact of stress, fear, and trauma on a victim's ability to listen to and process information, amplified if that is also in a second language and b) the archaic and obscure language that is a characteristic of the vocabulary used in law, particularly to a person in shock using a second language.

6.13 The only other assessment undertaken in this case, was by the National Probation Service (NPS) during the preparation of the Pre-Sentence Report in September 2019. This assessment is of the circumstances of the offence, the offender and the risks potentially posed by him to the current and future victims. It was prepared by an Officer from the National Probation Service (NPS), based on one interview with the defendant, access to Crown Prosecution Service (CPS) papers, Police information on the call outs and the Spousal Assault Risk Assessment (SARA) a specialist Domestic Abuse assessment of perpetrators. He was identified as posing a ‘Medium Risk of Harm’ as described above to the public and to future partners. This assessment was based both on his presentation and responses in the interview and statistical likelihood based on factors such as age, gender, number, and type of previous convictions.

6.14 Obviously given the events that have happened, this PSR has had no effect on the events that were shortly to tragically happen. The Panel would voice the following observations of the PSR from a point of view of learning from this case. The Panel accepts that at the time of assessment ‘Medium Risk of Harm’ was an accurate determination. Of concern to the Panel is the following statement written by the PSR author, “As evidenced by his behaviour when he consumes alcohol, he can easily default to an aggressive frame of mind in which he becomes unstable, emotionally volatile, violent, and abusive. I assess that the highlighted above risks will not reduce until Marc starts to demonstrate a lasting ability to maintain better behavioural control, address his anger, alcohol abuse and fully engages with the appropriate mental health team.” In the Panel’s view it seems the weight given by the report author to the role of alcohol in the offence precluded consideration of other factors - Coercive and Controlling Behaviour for which the evidence was available to the same level as that indicating alcohol.

6.15 The issues of Marc's mental health and ability to access treatment for that was not identified as a risk factor. The Hampshire Liaison and Diversion Service (HLDS) assessed Marc in custody on his return from hospital following the murder and found him to ‘appear to have full insight and capacity’, self-harm was considered and HDLS recommended to continue constant observation whilst in custody, as Marc could not guarantee his personal safety. The Panel recognise that the police record of the offence which the PSR author had sight of clearly links the perpetrator’s drinking to

the victim ending the relationship. This seems however to have led the PSR author not to consider other explanations linked to domestic abuse for which the evidence was also there- the duration of the destruction of property and the level of damage, the fear of the victim of further violence and harassment by him, and evidence of similar behaviours in the past. (all detailed in police records). The Panel is puzzled why this was not considered as the CPS Charging papers clearly indicated the fear the victim had of the perpetrator, when it records her as saying " I don't think that this is not the end as we have broken up in the past however he has been persistent in contacting me so we got back together….I am afraid he will try come to my home or even my work….I don't know how he is now thinking and if he will now hit me…I don't know what will happen with my home as I only rented this out around a month ago… Due to the damage I don't know if the landlord will kick me out and I will lose out on money and become homeless….I never want to see him again".[8] The Panel would suggest this should have alerted the officer to the risk of further harassment and potential Coercive and Controlling Behaviour.[9] as evidenced by the systematic destruction of her home, evidence of previous, and fear of further harassment by Marc. The PSR however makes no reference to domestic abuse, nor the presence of dynamic risk factors such as the perpetrator's acute substance abuse, mental health concerns and current suicidal thinking. This along with clear evidence of the recent separation which he opposed indicated that the victim was at considerable risk from Marc. The Short Form PSR made little reference to the continuing risk to Ana and others, apart from the risk assessment of Medium (that the offender had the potential to offend again but was unlikely to do so unless circumstances changed) and including a Restraining Order in the proposal.

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[8] Crown Prosecution Service Regina v 'Marc'

[9] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship The Government definition also outlines the following:

Coercive behaviour is an 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 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.

7. Conclusions

7.1 This Review has highlighted the following issues which have implications for future service delivery by the agencies involved. It is reassuring to see that the use of the DASH is clearly embedded within Hampshire Constabulary. However, this Review has highlighted several features in its use that undermine its value. Firstly, that Police Officers attending incidents in this case did not for some reason employ their own professional judgement as they are able to do in completing the DASH but allowed the responses of the victim to override the evidence available to them in crucial areas such as fear, harassment, Coercive and Controlling Behaviour and escalation. The reason for this is not clear to the Panel. The IMR from Hampshire Constabulary states that all Officers have received training relating to the dynamics of Domestic Abuse and Coercive and Controlling Behaviour. The panel believe that had the Officers responded to the observations they recorded in attending the incident, the risk assessment would not have been recorded as 'standard.' The disparity between incident and assessment and the Quality Assurance remarks do indicate the possibility of a 'numeric approach' being applied in this case.

7.2 Secondly from the files it seems that the PPN/DASH is not completed by the Officers attending but is completed later and by another Officer, as the first Officer felt a translator was needed but the second Officer felt Ana's English comprehension was sufficient. It must be noted that Ana was visibly shocked at the time, and this may have impacted on her use of English. This may explain the apparent discrepancy between the evidence recorded by officers in attendance and the DASH itself. In any event to the Panel, it appears a significant dislocation in the assessment process that will affect the quality and reliability of it. In addition, this case has clearly highlighted that the Quality Assurance process as it stands does not deliver the effective scrutiny and oversight that it needs to. The panel agree with the observations of the author of the Hampshire Constabulary IMR that the "quality assurer in this case failed to recognise an indicator as listed in the Standard Operating Procedure and categorised the case as Standard risk without referencing aggravating risk factors which are mentioned on the PPN1/DASH. They also failed to recognise the severity of the damage caused in this incident."

7.3 The arrest and remand in custody of Marc and obtaining a statement from the victim was done speedily and efficiently. Sadly, the time he was in custody was not well used and he was not interviewed and charged during this time which could have caused problems later, but fortunately did not. Immediately after Marc's release he breached his Bail conditions by approaching the area in which the victim lived, and the following day emailed her three times one of which was coercive and abusive. This did not result in a reassessment of the risk that Marc posed to Ana. This should have been good practice in any event, but the failure to do so, and perhaps reassess Ana as at Medium Risk meant that she was not offered enhanced support and monitoring. The Panel know that this error was made by a student Police Officer.

Mistakes are part of the learning process, and the same standards and expectations should not be made of those who are employed within a student role as is of others. The responsibility for this mistake lies either with the individual who was meant to be supervising the student officer or with Hampshire Constabulary for not ensuring effective oversight and supervision of the student.

7.4 The Panel is concerned that the Short Form PSR completed by the Probation Officer from Hampshire NPS mistakenly identified Marc's alcohol use and anger as the cause of the Criminal Damage offence he had committed. As identified above the Panel believe this does not recognise the issue of separation and the evidence suggesting Coercive and Controlling Behaviour as indicated by the testimonies of the victims and the evidence of the Officers attending. It may indicate a lack of awareness of the dynamics of domestic abuse and Coercive and Controlling Behaviour. This is particularly evident in the failure of the system relying on an individual officer to complete an assessment with limited information. Had the Probation Officer had sight of the Body Worn Camera footage of the Criminal Damage they may have been able to fully recognise the level in risk to the victim caused by the separation of Ana and Marc, even if the fear evidenced to the officers at the scene was not made available to the PSR author. There is also the concern that the focus in terms of reducing Marc's risk may have been directed mistakenly towards anger and alcohol during his sentence, rather than his abusive attitudes and beliefs.

8. Lessons to be Learnt

8.1 From the evidence available to the Panel there are clear lessons for Hampshire Constabulary in terms of administering and quality assuring the DASH. Firstly, attending officers' view of the incident, which from their records suggested Coercive and Controlling Behaviour were lost in the process of scoring the DASH. It is not clear whether this is an issue of confidence or reluctance to override the responses of the victim who may well have normalised to the abusive behaviour. Secondly, it seems that the DASH was completed by another Officer presumably that did not attend the original incident due to a mistaken belief Ana's use of English required an interpreter. The panel feel this can only reduce the accuracy of the DASH. It is also clear to the Panel that the Quality Assurance coordinators require further training, an issue already identified by the Child Abuse Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).

8.2 The failure to review the victim's risk following a further offence and Breach of Bail, all related to the same perpetrator and suggesting Coercive, and Controlling Behaviour should be examined, and practice reviewed. The Panel are assured by Hampshire Police that a system has been put in place to ensure that following up on initial risk assessments occur later by the allocated investigating officer. These are now following a proforma to cover areas of risk and safeguarding at intervals or following a possible change/new offence.

8.3 The level of oversight of Student Police Officers and the level of responsibility they are personally expected to carry should be reviewed, with an expectation that more oversight and closer supervision of day-to-day practice is introduced. The Panel strongly believe Hampshire Constabulary should have reviewed the risk assessment of the victim and feel there were at least two trigger points which should have prompted such a review.

8.4 The Panel would also suggest that the case has highlighted a gap in the ability of the NPS to recognise 'and respond to Coercive and Controlling Behaviour within the PSR process.

8.5 The pressure on Hampshire Constabulary to release without charge was in part caused by poor planning during his period in custody and in part by the lack of interpreters.

8.6 It may be useful to explore the reasons for the Court's rejection of the application for remand in custody following the perpetrator's second breach of police bail so that lessons can be learnt and applied in similar future situations. Had the Court had sight of the extreme level of the criminal damage through either a written report or sight of the Body Worn Camera footage the likelihood of a remand in custody would have been higher.

9. Recommendations

9.1 That Hampshire Constabulary as a matter of urgency implement the further training identified by the Child Abuse HMICFRS report for the Quality Assurance coordinators (QA's) relating to the DASH. The Panel would suggest that either subject matter experts are used to undertake the quality assurance process itself, or if Hampshire Constabulary decide to continue using internal staff as subject matter experts that a process of assessment and a means of demonstrating competence in the role should be evidenced as a condition of taking that role. This could be achieved by training a cohort of QAs by a subject matter expert using a case study completed by the candidates to be assessed and marked using a model pro forma. Graduation to a QA role will be dependent upon completing that case study to a satisfactory standard.

I. The Panel have been assured that it was an exception that an Officer who was not at the incident completed the DASH. The Panel were assured that the use of 'professional judgement' in assessing DASH has been reinforced in training sessions, supervision, and on-line messaging via Hampshire Constabulary communications systems. The Force has already developed a method by which good practice is identified and shared through the Force using a variety of methods to reinforce good practice.
II. That all assessment documents completed by student officers with implications for the safety of adults at risk or children be either completed or quality checked by an experienced officer.
III. That practice in completing DASH by officers be regularly scrutinised by the dip sampling of completed DASHs as part of supervision and appraisal.
IV. Hampshire Constabulary assure Southampton Safe City Partnership that their provision of interpreters for victims and suspects for whom English is not their first language is fit for purpose.

9.2 That Hampshire NPS review the knowledge and awareness of its frontline staff in the dynamics of Domestic Abuse, focussing particularly on identifying and managing 'Coercive and Controlling' Behaviour, and the dynamic risk factors that indicate risk to victims. And that it provides learning opportunities for front line staff -particularly those involved in the assessment process both in the community and in custodial settings - those writing PSR's, assessment reports for Parole, Conditional Release etc to identify risk to victims from perpetrators as outlined in P12 HMPPS Domestic Abuse Policy Framework 2020.

9.3 The failure of Ana's employer to allow her colleagues and line manager to be interviewed by the Review is of concern. As a significant employer in the Southampton area, they have a relationship with the Local Authority. The Review

recommends that the relevant business support departments in the City Council encourage all employers with whom they have a working relationship to adopt a Domestic Abuse Policy for their employees. In line with the best practice identified in the Department of Business, Energy, and Industry 'Workplace Support for Victims of Domestic Abuse' 2021[10]. All Employers can be directed to the Employers Initiative on Domestic Abuse [11] who provide at no cost advice and guidance on establishing a Domestic Abuse Policy and how to practically support staff facing these issues.

9.4 The Home Office share this DHR with the Ministry of Justice in light of information available at Bail hearings as our understanding is the file size for Body Worn Camera footage cannot be currently accommodated in the Courts IT system.

[10] https://www.gov.uk/government/publications/workplace-support-for-victims-of-domestic-abuse/workplace-support-for-victims-of-domestic-abuse-review-report-accessible-webpage
[11] https://www.eida.org.uk/

Appendix 1: Methodology for the overview report

Data Analysis

The panel reviewed the Police and Probation Service IMRs in a panel meeting in July 2020. The Panel discussed the chronology of events and draft recommendations in an inclusive and collaborative way, which involved all members in reflective learning. It was a generative process which encouraged us to ask the aspirational question – 'what a safe system would look like?' The outcomes from this process have formed the basis of the review recommendations.

It must be acknowledged that any review opens anxieties, but it was the panel's intention to create a culture of accountability and learning not of culpability or blame. The review panel were unanimous in wanting to value the actions and approaches that worked well, whilst facing the tough issues of what else could or should have been offered. This was to produce effective recommendations which seek to make others confronted by these complex situations safer.

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked Restricted. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the final report in full to remain RESTRICTED and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel.

Appendix 2 Terms of Reference

1. Introduction

This Domestic Homicide Review is commissioned by the Southampton Community Safety Partnership in response to the homicide of Ana in September 2019.

This Domestic Homicide Review (DHR) was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself

The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

Jan Pickles OBE has been appointed as Chair of the review panel at the Review Panel meeting held in November 2019.

The Victim was a Spanish National who at the time of writing these Terms of Reference was believed to have lived in the UK for three years moving from Spain to Liverpool with the perpetrator (also a Spanish National) then settling in Southampton.

2. Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident in September 2019 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the perpetrator.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

Consider the period from September 2016 to September 2019 subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

Establish contact with the Liverpool Community Safety Partnership to scope which services had contact with the victim and perpetrator whilst resident in that area.

Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.

Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

Take account of the coroners' inquest in terms of timing and contact with the family.

Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report within six months after completion of the criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.
- To consider the impact of the victims and perpetrators nationality on agency responses.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?
- Was the perpetrator known to domestic abuse services, was the incident a one off or were there any warning signs.

- Were there any barriers experienced by the victim or family, friends, and colleagues in reporting the abuse.
- Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?
- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
- Consider any equality and diversity issues that appear pertinent to the victim, perpetrator.
- Was the perpetrator known to have a history of DA, if so, what support was offered to the perpetrator?
- Were staff working with the perpetrator confident around what service provision is available around DA locally?
- Consider any equality and diversity issues that appear pertinent to the perpetrator?

4. Family involvement

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process. Bearing in mind that the victim was a Spanish National the Review is committed to ensuring that distance nor language should be a barrier to involvement in this process by her family.

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 of the coroner's inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

5. Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. Each statutory agency may seek their own legal advice at their own discretion and cost.

6. Panel members, expert witnesses, and advisors

The following agencies and individuals are suggested to participate in the review panel (as above Section 2). At the time of drafting these Terms of Reference the Panel are confident its membership has specific expertise in domestic abuse but as the review progresses it may identify specific areas of expertise required and will seek this expertise if necessary.

7. Media and communication

The management of all media and communication matters will be through a joint team drawn from the statutory partners involved. There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention.

However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the review is working closely with the family throughout the process. An executive summary of the review will be published on the CSP website, with an appropriate press statement available to respond to any enquiries.

The recommendations of the review will be distributed through the CSP website and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

8. Data Protection Act 2018 and General Data Protection Regulations

A Personal Information Sharing Agreement has been produced to facilitate the exchange of personal information to meet the aims of a DHR and the requirements of data protection legislation.

Domestic Homicide Review Executive Summary

Commissioned by the Southampton Community Safety Partnership

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of ‘Ana’ who died in September 2019

Review produced by Independent Chair Jan Pickles OBE

Date report completed: 01.07.22.

Contents

1.THE REVIEW PROCESS

This Executive Summary outlines the process undertaken by Southampton Community Safety Partnership area domestic homicide review panel in reviewing the murder of Ana whose death occurred in September 2019.

As the family felt unable to choose the pseudonyms used in this report, the Panel agreed that the victim would be referred to as Ana in recognition of her Spanish heritage and the perpetrator as Marc.

Marc received a Life sentence with a minimum term of 19 years in prison in March 2021 at Winchester Crown Court for her murder. The presiding Judge Jane Miller QC described his behaviour as " a savage, ferocious and sustained attack with a knife." Ana died from twenty-three stab wounds, with four stab wounds to the heart. The weapon was a kitchen knife.

Ana was a Spanish woman aged 28 years old at the time of her death. The Panel has not identified any other Protected Characteristics named in the Equality Act 2010.

Marc the perpetrator was aged 30 years old at the time of her murder was of Moroccan origin but had grown up in Spain. He had experienced an episode of self-harm some years before whilst living in Liverpool, but no further information was found regarding his mental health at the time of the murder. A Psychiatric report was prepared for the trial which the Panel did not have sight of. The Panel has not identified any other Protected Characteristics as named in the Equality Act 2010.

The DHR process began with an initial meeting of the Safe Southampton Partnership (SSP) in October 2019. They concluded that Ana's death did meet the Home Office criteria and the decision to hold a Domestic Homicide Review (DHR) was agreed. Fifteen agencies that potentially had contact with Ana or Marc prior to the point of the murder were contacted and asked to confirm whether they had involvement with them and if to secure their files.

Ana and Marc had previously lived in Liverpool and the Community Safety Partnership in Liverpool was contacted and asked to scope out if any agency in the City had contact with either Ana or Marc. Information was received from Liverpool which outlined one incident with the emergency services which involved the Police, the Ambulance Service and a brief period of hospital care related to an incident when Marc had drunk bleach, he made no disclosure discharged himself before a psychiatric assessment. The Panel were assured this was the extent of the information those service held and agreed this limited information did not require any further investigation.

The DHR Panel agreed of the fifteen agencies contacted in Southampton only two agencies had relevant information and they were asked to produce Individual Management Reviews (IMRs).

The DHR was in turn delayed by the delay to the Criminal Justice process by the Covid-19 pandemic. The Senior Investigating Officer did arrange for the Chair to

meet with Ana's parents and cousin briefly prior to the trial in July 2020. The trial concluded in February 2021 and Marc was sentenced in March 2021.

Ana's parents were supported by a Family Liaison Officer (FLO) with the assistance of Consular staff. The Chair ensured they were provided by a leaflet from Advocacy After Fatal Domestic Abuse (AAFDA) in Spanish explaining the DHR process and letters from the Chair to them were translated into Spanish. The Chair at her meeting with them in July 2021 outlined the DHR process, offered to arrange a victim support service in Spain and suggested they may wish to meet with others in Spain who had experienced a similar tragedy. This offer was based on the Chairs own contacts with the Spanish Violence Against Women Services. However, Ana's parents did not wish to take up these offers with her mother confiding that almost a year after Ana's death she had only been able to briefly speak with her best friend she described them as a private couple. The Chair wrote to them and Ana's cousin who had acted as a translator for them (these letters were again translated into Spanish) in May 2022 with an offer to meet with them at their home in June 2022 they were not able to respond.

Following his sentence, the Chair wrote to Marc (also translated into Spanish) offering to visit him in custody, this letter was delivered by the Probation Service so that the process could be explained to him, he chose not to co-operate.

2.CONTRIBUTORS TO THE REVIEW

The following agencies were required to produce an Individual Management Reviews (IMRs) on behalf of their organisation. These IMR's were completed by a member of staff who had not had contact directly or undertaken an immediate line management. The IMRs were signed by a senior member of that agency before being presented by their authors to the Domestic Homicide Review Panel.

- Hampshire Police
- The National Probation Service

3.THE REVIEW PANEL MEMBERS

The following agencies were invited to be part of the DHR Panel. All members were representatives of their respective organisations and had had no direct or line management responsibility for services provided to Ana or Marc. The organisations and members are stated as they were at the time the review was commissioned. It is acknowledged that some organisations have undergone change since then.

Agency Representative	Role	Name
Independent Chair	Chair and Author	Jan Pickles
Domestic and sexual Abuse Service Southampton City Council	SCC Independent Domestic Violence Advisory Service Manager (IDVA)	Karen Marsh
Chief Executive and Deputy Chief Executive	The Hampton Trust	Chantal Hughes Tracey Rutherford

Domestic and sexual Abuse Service Southampton City Council	Asst Domestic and sexual Abuse Service Co-ordinator (minutes)	Kerry Owens
Hampshire Constabulary	Serious Case Reviewer	Grace Mason Bryan Carter
Southampton City Clinical Commissioning Group	Head of Safeguarding	Katherine Elsmore
Safe City Partnership, Southampton	Chair of Partnership	Mick Thompson
HM Prisons & Probation Service	Senior Probation Officer,	Jenny McKie TJ Abrahams
Southampton City Council	Senior Policy, Partnerships Officer	Andrew Saunders
Public Health Southampton City Council	Public Health Consultant	Charlotte Mathews
Southampton City Council	District Housing Manager	Helen Prophett
Southampton City Council	Senior Commissioning Manager	Sandra Jerrim
Southampton City Council	Safeguarding Adults Team Manager	Eric Smith

4.AUTHOR OF THE OVERVIEW REPORT

Jan Pickles OBE was appointed as Independent Chair of the DHR and author of this report in September 2019. She is a qualified and registered social worker with over forty years' experience of working with perpetrators and victims of domestic abuse, coercive control, and sexual violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of domestic abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for the development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she received the First Minister of Wales's Recognition Award for the establishment of services for victims of sexual violence. She has held roles as a Probation Officer, Social Worker, Social Work Manager, Assistant Police and Crime Commissioner and as a Ministerial Adviser. She is currently an Independent Board member on an NHS Trust and a member of the National Independent Safeguarding Board for Wales. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

Jan Pickles is not currently employed by any of the statutory agencies involved in the Review (as identified in section 9 of the Act) and have had no previous involvement or contact with the family or any of the other parties involved in the events under Review.

5.THE TERMS OF REFERENCE FOR THE REVIEW

1. Introduction

This Domestic Homicide Review is commissioned by the Southampton Community Safety Partnership in response to the homicide of Ana in September 2019.

This Domestic Homicide Review (DHR) was commissioned because it meets the definition detailed in paragraph 12 of the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2016). The key purpose of undertaking domestic homicide reviews (DHR) is to identify the lessons to be learnt from homicides 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself

The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004.

Jan Pickles OBE has been appointed as Chair of the review panel at the Review Panel meeting held in November 2019.

The Victim was a Spanish National who at the time of writing these Terms of Reference was believed to have lived in the UK for three years moving from Spain to Liverpool with the alleged perpetrator (also a Spanish National) then settling in Southampton.

2. Purpose of the review

The purpose of the review is to:

- Establish the facts that led to the incident in September 2019 and whether there are any lessons to be learned from the case about the way in which professionals and agencies worked together to safeguard the family.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the perpetrator.

Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

Consider the period from September 2016 to September 2019 subject to any information emerging that prompts a review of any earlier incidents or events that are relevant.

Establish contact with the Liverpool Community Safety Partnership to scope which services had contact with the victim and alleged perpetrator whilst resident in that area.

Request Individual Management Reviews by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies or individuals identified through the process of the review.

Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

Take account of the coroners' inquest in terms of timing and contact with the family.

Produce a report which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Aim to produce the report within six months after completion of the criminal proceedings, responding sensitively to the concerns of the family, particularly in relation to the inquest process, the individual management reviews being completed and the potential for identifying matters which may require further review.
- To consider the impact of the victims and perpetrators nationality on agency responses.

In addition, the following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Was the victim known to domestic abuse services, was the incident a one off or were there any warning signs. Could more be done to raise awareness of services available to victims of domestic abuse?
- Was the perpetrator known to domestic abuse services, was the incident a one off or were there any warning signs.
- Were there any barriers experienced by the victim or family, friends and colleagues in reporting the abuse.
- Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by the victim that were missed?
- Are there any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of the services available?
- Consider any equality and diversity issues that appear pertinent to the victim, perpetrator.
- Was the perpetrator known to have a history of DA, if so, what support was offered to the perpetrator?

- Were staff working with the perpetrator confident around what service provision is available around DA locally?
- Consider any equality and diversity issues that appear pertinent to the perpetrator?

4. Family involvement

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process. Bearing in mind that the victim was a Spanish National the Review is committed to ensuring that distance nor language should be a barrier to involvement in this process by her family.

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 of the coroner's inquest and ensure that the family are able to respond to this review and the inquest avoiding duplication of effort and without undue pressure.

5. Legal advice and costs

Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. Each statutory agency may seek their own legal advice at their own discretion and cost.

6. Panel members, expert witnesses and advisors

The following agencies and individuals are suggested to participate in the review panel (as above Section 3). At the time of drafting these Terms of Reference the Panel are confident its membership has specific expertise in domestic abuse but as the review progresses it may identify specific areas of expertise required and will seek this expertise if necessary.

7. Media and communication

The management of all media and communication matters will be through a joint team drawn from the statutory partners involved. There will be no presumption to inform the public via the media that a review is being held in order to protect the family from any unwanted media attention.

However, a reactive press statement regarding the review will be developed to respond to any enquiries to explain the basis for the review, why and who commissioned the review, the basic methodology and that the review is working closely with the family throughout the process. An executive summary of the review will be published on the CSP website, with an appropriate press statement available to respond to any enquiries.

The recommendations of the review will be distributed through the CSP website and applied to any other learning opportunities with partner agencies involved with responding to domestic abuse.

8. Data Protection Act 2018 and General Data Protection Regulations

A Personal Information Sharing Agreement has been produced to facilitate the exchange of personal information to meet the aims of a DHR and the requirements of data protection legislation.

6.SUMMARY CHRONOLOGY

6.1 The following background information (6.1 – 6.4) had been kindly provided by Ana's family, between whom there was a close and loving relationship. Ana and Marc first met in 2009 when they both lived in the same small town in Spain. Ana and Marc began living together soon after Ana returned from a short study trip to England Then Ana went to Lyon, France for a few months working in a hotel and Marc stayed in Spain. In 2018 Ana returned to the UK with Marc, initially living, and working in Liverpool, both worked for a UK based shipping company.

6.2 In February 2019 Ana returned home to her parents in Spain, believing that Marc had been unfaithful to her. Marc remained in Liverpool where in April 2019 reports state he self-harmed by drinking bleach and taking paracetamol. Marc told his parents what he had done, and they alerted the Police in Liverpool. He was taken by Ambulance to Hospital but discharged himself prior to the routine Psychiatric assessment. Marc then returned to Spain. It is reported the couple reconciled after a brief period of Ana refusing to see him, but the exact status of their relationship in this period is not known.

6.3 Ana and Marc then returned to the UK together in 2019, staying in London in June 2019 and then moving to Southampton, where they found employment and moved into shared accommodation. At this point according to statements made to the Police by Ana's friend and housemate they had not resumed their relationship. They later moved into the rented house in which Ana was killed. Ana's friend was also living at the property. In addition, it is known that Ana sub-let part of the accommodation via 'Airbnb.' There is no information relating to this arrangement other than a police report of Ana alleging theft of money by two guests sometime in late August 2019. At some unknown point either prior to or following their return to Southampton Ana and Marc resumed their relationship.

6.4 There is no further information held by agencies concerning Ana and Marc until late August 2019 when Marc was arrested by Hampshire Constabulary Officers on suspicion of driving under the influence of alcohol. He was processed and found to be over the legal limit to drive, charged and later sentenced at Southampton Magistrates Court to a driving disqualification and fine.

6.5 The next day in late August 2019, Police Officers attended the property of Ana and Marc following a 999 call from Ana's housemate. Police Officers observed the

damage to the furniture, fixtures, and fittings in the property which they described as ‘substantial.’ Ana stated to the officer completing the DASH “that after asking him to leave as she wanted to end the relationship due to ‘his drinking and volatile behaviour, Marc had begun to smash Ana’s belongings and the property”. Ana’s flatmate stated that he had ‘systematically destroyed it ‘. His actions were described as ‘frenzied’ in which he ripped radiators and a toilet from the walls, threw furniture and fittings from the upstairs windows and ‘destroyed everything’ in the property. The Chair of this Review has viewed the body worn camera footage from attending Police Officers which shows the extreme nature of the damage and the arrest of Marc for Criminal Damage. Despite this extreme behaviour, at the time of the arrest he presented as calm and compliant at the scene and was well managed by the attending Officers. At the time of his arrest, Ana and her friend could be seen on the pavement outside by police, ‘obviously fearful for their safety.’ Police reports state that Ana described his drinking and general behaviour becoming worse and that he was becoming increasingly ‘volatile.’ She also stated she believed that ‘he was taking crack Cocaine as she had seen some white powder in his car’. During the incident it is reported that Ana sustained a bruise to her leg, and that her arm was also bruised.

6.6 The Hampshire Constabulary IMR states that Ana’s friend informed the attending Officer that she was worried that Marc would harass Ana as he had done so before when they had separated. However, there is no record within Hampshire Constabulary of previous separations and no further mention of them on the Record Management System (RMS). The Hampshire Constabulary IMR notes that the attending officer had recorded that the victims had stated that Marc’s behaviour was getting worse, with increased alcohol use and volatile behaviour, and that Marc had gone into a ‘rage’ when Ana told him she intended to sperate from him and that “He had damaged her phone so that she was only able to be contacted by her flatmate.” A statement was taken, and a DASH [12]Public Protection Notice 1 form (PPN1) was completed. Ana answered a positive response to six of the questions asked and was accordingly assessed as at ‘Standard Risk’ by the DASH. The Hampshire Constabulary IMR author notes that Force Procedure defines ‘Standard Risk’ as ‘Current evidence does not indicate a likelihood of causing serious harm.’ The IMR

[12] Most forces use the Domestic Abuse, Stalking, Harassment and Honour-Based Violence risk identification, assessment, and management model (DASH). DASH is also used by partner agencies, providing a consistent approach ttps://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/risk-and-vulnerability/

from Hampshire Constabulary states that a Domestic Violence Prevention Notice[13] (DVPN) was considered but not actioned as there was no previous history of Domestic Abuse, “Marc had been excluded from the property by Ana and he was stating his intention to leave the country on a pre-booked plane ticket in the coming weeks.”

6.7 A standard PPN1 was submitted to Victim Support, the following day in August 2019, as per the Hampshire Referral Pathway for Standard Risk PPN1’s, Victim Support confirmed they had no contact with Ana. This PPN1 was also shared with Southampton Police Safeguarding Coordinators at the Hub (referred to locally as the MASH but not a multi-agency arrangement as in other areas) for quality Assurance purposes, as is required practice. The Hampshire Constabulary IMR states that “the Police Safeguarding Coordinators reviewed the DASH and applied a Standard risk grading. The justification section states simply “6 yes answers on the PPN. 0 previous incidents within three last 3 months.” Accepting the attending officer’s judgement in terms of their Risk rating.

6.8 Marc was arrested and held in Police custody. The IMR from Hampshire Constabulary notes that “despite the statement of complaint being taken that evening from the victim, and Marc being in Police Custody, no attempt was made to arrange an interpreter for the interview of Marc until the following morning”, by which time there was no possibility of completing all of the required steps within the initial 24-hour custody timeframe, a Superintendent was not approached to extend this time period to 36 hours. Consequently, the decision was taken to Bail Marc with conditions to return to the Police Station two days later in late August 2019 for interview, when an interpreter would be available. The conditions of Bail were, “not to contact Ana directly or indirectly, and not to attend the home where she lived, and Marc had caused the damage.” This delay in processing Marc meant that Officers had to release Marc at this point without charge.

6.9 In line with standard procedure the Officer in the case attempted to contact Ana to inform her that Marc was to be released but was unable to do so. Instead, and in

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[13] 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.
A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support, they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates’ court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim.

line with police force protocol, the officer sent a text to her and arranged for a hand delivered letter to be taken to Ana's address with details of the bail process. He also alerted the local police neighbourhood team to the situation. The Hampshire Constabulary IMR author has noted that although there are prompts to do so, the release decision making process did not lead to any further evaluation of the risks presented in terms of Ana's safety following Marc 's release.

6.10 At some point in late August 2019, the Panel do not know whether before or after the offence of criminal damage, it is reported by a member of Ana's family that Marc had said that he wanted Ana to 'drop' the charges against him, this was not reported to the Police. It is also reported that Ana had told her parents about her intention to end the relationship with Marc before he had damaged the house. Ana was reported to have been ringing her parents daily due to her fear of him. Her parents stated they believe Ana was reassured by the bail conditions (which they described as a 'Restraining Order') then in place, despite Marc continuing to attempt to contact her. Her parents stated that Ana did not want to return to Spain as she was enjoying her job. Ana had not told her mother that Marc had threatened her, and they believed that Ana was not afraid of him. The Panel are aware that Ana had asked her manager if she could continue to work for the company from Spain, but this had been denied.

6.11 The Hampshire Constabulary IMR author states that there appears to have been no safeguarding review or summary, at any later stage in the investigation, after the completion of the PPN form. There is also no evidence that the College of Policing Authorised Police Practice (APP)[14] on pre-release considerations was used by the Officer in the case or anyone else involved in the process; this could have focussed on updating the risk assessment and conducting further safety planning with the victim.

6.12 Hampshire Police received a message the next day that Marc had breached his Bail conditions, seen by Ana and her flatmate entering the road in which they lived. As a result, Ana and her flat mate arranged to move into a City Centre hotel which they felt would provide more safety for them. Later that day Police Officers attended the hotel they were was staying at and felt satisfied that it provided Ana and her flatmate with sufficient safety and that no further action was required from them. The decision was taken not to find and arrest Marc in response to this breach of Bail due to procedural concerns, but to charge, arrest and interview Marc and seek his

[14] College of Policing Authorised Police Practice https://www.app.college.police.uk/app-content/detention-and-custody-2/response-arrest-and-detention/

remand in custody when he answered Bail at the Police station as required two days later.

6.13 The following day, Ana reported to the Police that overnight she had received three emails from Marc, one of which was abusive calling her a 'whore.' This was recorded as a 'Malicious Communications Offence' and a Breach of Marc's Bail conditions. The Hampshire Constabulary IMR author believes that it was also decided to address this further offence and the earlier Breach of Bail when Marc returned to the police station to answer his Bail the following day. The Hampshire Constabulary IMR author notes that "There was no reassessment of risk, but that the immediate safeguarding measures discussed before still applied, that Ana and her friend were staying in a hotel that Marc did not know about." The decision was made to arrest and interview Marc in relation to all matters when he answered Bail the following day in late August 2019 and to seek a remand in custody at Court.

6.14 Marc attended the Police Station as required at the end of August 2019 and was charged with Criminal Damage, Breach of Bail and Malicious Communications offences and held in Police custody. The next day Marc appeared at Southampton Magistrates Court and pleaded Guilty to all matters put to him. A Pre-Sentence Report (PSR) was requested, and case adjourned for three and a half weeks until late September 2019 for sentencing. He was released on Conditional Bail with the following Conditions is) not to contact directly or indirectly Ana. ii) Not to enter Ana's Street in Southampton except on one occasion when in the presence of a Police Officer to collect his belongings. iii) To live and sleep each night at a certain address in Southampton.

6.15 Marc appeared at Southampton Magistrates Court in mid-September 2019 and was fined in relation to the drink driving charges. Marc attended his interview for the PSR[15] as required. The IMR from the Probation Service has provided the 'Short Format' PSR prepared for Marc's sentencing to the Panel. The Panel would note that the PSR states that the defendant "displayed aggressive, controlling and risk-taking behaviour," and that a Spousal Assault Risk Assessment (SARA) a specific Domestic Abuse checklist was used which identified him as a moderate risk- which indicates that some risk factors were identified. Despite this there is no mention of

[15] HM Prison &Probation Service, Determining Pre-Sentence Reports 2016. (Revised 26.6.2021) The purpose of a pre-sentence report (PSR) is to facilitate the administration of justice, to reduce an offender's likelihood of re-offending and to protect the public and/or victim(s) from further harm. A PSR does this by assisting the court to determine the most suitable method of sentencing an offender (Sentencing Act 2020, section 31). To achieve this, the Probation Service provides an expert assessment of the nature and causes of the offender's behaviour, the risk the offender poses and to whom, as well as an independent recommendation of the option(s) available to the court when making a sentencing determination for the offender. National report templates are used for reports completed.

the offence being considered as one of domestic abuse in the PSR and the offending behaviour and impact considered in the light of that. Added to this there is within the PSR information that suggests dynamic risk factors to be active- a recent further offence, the ongoing mental health concerns, suicidal thinking, an inability to access treatment and the recent separation and the risk in terms of the victim which were not identified as such to the Court and may have been overridden by the low 'actuarial' scores of the RSR (Risk of Serious Recidivism) and OGRS(Offender Group Reconviction Score) in terms of assessing risk to his ex-partner. [16]
The report could have been more targeted than it was in identifying and addressing the issue of domestic abuse. The report author did propose a restrictive condition- the Restraining Order, but there were no other measures to address the perpetrator's abusive thinking and behaviour, as the Panel believe would have also reduced the risk he presented to Ana and others. The court appearance to answer those charges was superseded by the death of Ana and Marc's further remand in custody in relation to that charge. Whilst this report did not affect the tragic death of Ana it does provides an opportunity to consider assessment and report writing practice in relation to cases of domestic abuse and in particular the need to protect the victim from the perpetrator by restrictive and protective measures relating to the perpetrator.

6.16 The day after Marc's Court appearance for the Drink Drive offence in September 2019, Ana informed her line manager at a planned supervision meeting that she had been in an abusive relationship with a long-term boyfriend. Ana was tearful and confided that there were occasions when she had to come into work afraid of meeting Marc. Ana made a request to work from her home in Spain and shared that she was considering resigning due to the behaviour of her ex-partner. This request was denied her due to the length of time she had been employed by the company.

6.17 In late September 2019, Ana was attacked by her ex-partner with a kitchen knife in her home and pronounced dead by the attending South Central Ambulance Service at the scene. Ana had been on a date in Southampton with a Spanish male. He later said that Ana believed she had seen Marc at the pub earlier that evening. CCTV played at the trial showed that he followed Ana into her home, and that Ana's friend waited outside as he was concerned for her. He then forced entry when he heard shouting and screams inside the house. He stated that he saw Marc on top of Ana, stabbing her repeatedly with a knife.

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[16] For information on OGRS & RSR see pp 6 &16 RISK OF SERIOUS HARM GUIDANCE (2020) ttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1060610/Risk_of_Serious_Harm_Guidance_March_2022.pdf

7.KEY ISSUES ARISING FROM THE REVIEW

7.1 The first contact that any services had with the victim was following the 999-call made to the Police by her flatmate in late August 2019. Police Officers responded promptly, in just under 20 minutes to the call. Correct procedure was followed, the arrest of the perpetrator and interviewing the two victims of the Criminal Damage separately. The offence was correctly viewed as one of domestic abuse- a DASH and a PPN1 was completed. The DASH was also forwarded onto the Police Safeguarding Coordinators for quality assurance, and the assessment reviewed in line with service protocol. It was noted by the attending officers that the damage was 'substantial,' and that Ana had sustained bruising to her knee and her arm. Ana could not remember how they occurred, but it was believed to have been within the time of the incident. Both Ana and her friend voiced fear of the perpetrator should he be released. The body worn camera footage shows the attending Police Officers dealing with the perpetrator in a skilful manner and being supportive to Ana and her housemate.

7.2 Although a PPN and DASH were completed, many of the features of abusive behaviour which the Panel feel to have been present were not identified and consequently the level of risk, we believe underestimated. The risk of harm within the DASH was wrongly assessed as 'Standard' rather than 'Medium,' based on the extreme nature of the damage to the entire property and the degree of force/anger required to rip out a toilet and radiators and to smash up all furniture into no more than broken pieces of wood. Both Ana and her housemate had expressed fear of the perpetrator and the flatmate described previous separations and controlling behaviours. The 'Standard' assessment meant no follow-on Police support would be offered or provided.

7.3 The Hampshire Constabulary IMR describes a disconnect between the evidence at the scene available to attending Officers and the DASH assessment itself. The Officer answered 'No' to the Domestic Abuse, stalking and Harassment question and all the following questions in the 'Domestic Abuse' section of the DASH, despite evidence to the contrary available to the officers. Ana was also mistakenly classified as an 'ex-partner' thus diminishing the issue of separation which was very real. The officer identified a number of risk factors- the bruising sustained by Ana, Marc's substance misuse, depression, previous suicide attempts, and deteriorating behaviour and the fear expressed of his return to them. These aggravating factors do not seem to have been considered by the Officer completing the PPN/DASH. The Panel believe it likely the answers given by the victim rather than the officer's judgment drove the assessment, and that the statement made by the perpetrator of his returning to Spain provided false reassurance.

7.5 The Hampshire Constabulary IMR author reviewing this case believes that the underestimation of risk in the DASH may have been due to a different officer completing the form from the one that attended the call and not witness either the

scale of the damage caused or seen and heard the fear held by the victims of Marc. The IMR author stated that they had spoken to the officer concerned and confirmed that the victim's statements and lack of previous domestic abuse incidents drove his decision. In addition, the officer did not attend the original incident and therefore did not have first-hand knowledge of the degree of damage and fear caused by the perpetrator. Finally Force guidance states that 'Standard' risk assessment rating should be reserved for cases 'Where no indicators are present.' This should have applied in this case.

7.6 The assessment was then signed off as 'Standard' by the Police Safeguarding Coordinator As a result of this enquiry the sign off was checked again and again confirmed by the Safeguarding Coordinator as correct, due to "the lack of any previous domestic violence history involving the couple on RMS and the fact that the violence offered was against property and not against the individual" The coordinator acknowledged that Ana had sustained a bruise during the incident but stated that they considered this very minor and that there was no suggestion that it was caused intentionally by the perpetrator. The coordinator added that they did not consider that the amount of damage was a factor in assessing the level of risk. The coordinator felt that the issue of separation was not relevant in this case. This assessment is flawed in the view of the Panel and ignored several aggravating factors known at the time and described above. There is no record of whether Coercive and Controlling Behaviour was considered, which [17]requires 'a pattern of behaviour' and evidence of a 'serious effect' on the victim. Ana's friend had already shared a history of previous harassment by Marc with Officers, and both were witnessed as being visibly fearful on the street during the actual offence. As noted by the Hampshire Constabulary IMR author "Professional judgement of all of the information on the DASH assessment should, in the author's view, have meant that this case was graded higher than Standard."

7.7 The Panel note that although working in the UK, English was Ana's second language and that her responses to these sensitive questions at the scene when she and her housemate were clearly shocked and fearful could have been compromised

[17] https://www.cps.gov.uk/crime-info/domestic-abuse 'Controlling or Coercive behaviour' describes behaviour occurring within a current or former intimate or family relationship which causes someone to fear that violence will be used against them on more than one occasion or causes them serious alarm or distress that substantially affects their day-to-day activities. It involves a pattern of behaviour or incidents that enable a person to exert power or control over another, such as isolating a partner from their friends and family etc.
Coercive behaviour is an act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'

by her use of English. The possibility that this may have affected her responses to the questions do not appear to have been considered.

7.8 Valuable time was lost after Marc's arrest which had consequences later for managing Marc and safeguarding Ana and her housemate. Nothing was done in terms of processing Marc until the following morning when it was realised an interpreter was needed. This meant that Marc had to be released due to PACE timelines without being formally charged on Conditional Bail, to return in two days' time.

7.9 The following day after release Marc was seen by Ana and her housemate entering the road on which they lived, prohibited by the Bail Conditions set and they informed the Police. They saw him on their way to a city centre hotel which they had booked for two days as the property was uninhabitable. However, because an interpreter had not been arranged in time after his arrest Marc had not been charged in relation to that offence. He could not be arrested or charged due to the impact on the PACE timeline. This meant that a further risk assessment was not triggered, and the Breach of Bail was not able to be factored in as an aggravating factor. Had it been it could have led to a revision of the 'Standard Risk' assessment and more protective measures being offered to the victims.

7.10 The next day Marc sent three emails to Ana, one of which was threatening and abusive, and Marc was arrested and charged with that offence in addition to the earlier offences of the two previous days, when he attended the Police Station to answer Bail. Police Officers did not review the risk of harm that Marc posed to Ana on the PPN1 in the light either of the two later offences. The Police IMR author acknowledged that had a review been done it would likely have led to the revision of Ana's risk, which may have been amended to 'Medium', providing the opportunity to access additional support and monitoring. As stated earlier the Panel do not know if Ana would have taken up the offer of help, but the offer should in the Panel's view have been made. The Officer allocated to the case, was a student Police Officer and noted that he was aware of the original risk assessment but did not review or change it as the investigation progressed and as further risk became apparent as good practice requires. It is significant that there was no recorded supervisory oversight of the case which had there been likely would have directed him to review in line with policy.

7.11 In summary there is evidence of a chain of events in which the understanding of the impact of Marc's behaviour and the fear that Ana and her housemate had of him was lost when the PPN and DASH were completed. This seems to have been due to the responses made by Ana to the questions asked of her in completing the DASH weighing more heavily than the other evidence available to the officers at the scene. This initial error was compounded by the failure of the quality assurance process to correct or question the initial assessment and instead to confirm it. Further opportunities to reassess the original assessment were missed due in the first

instance perhaps due to the inexperience of the student Police Officer, and the lack of oversight by a more experienced officer of their practice, and the focus on ensuring actions were consistent with PACE timelines.

7.12 The only other assessment undertaken in this case, was by the National Probation Service (NPS) during the preparation of the Pre-Sentence Report in September 2019. This assessment is of the circumstances of the offence, the offender and the risks potentially posed by him to the current and future victims. It was prepared by an officer based on one interview with the defendant, access to Crown Prosecution Service (CPS) papers, Police information on the call outs and the Spousal Assault Risk Assessment (SARA) a specialist Domestic Abuse assessment of perpetrators. He was identified as posing a 'Medium Risk of Harm' as described above to the public and to future partners. This assessment was based both on his presentation and responses in the interview and statistical likelihood based on factors such as age, gender, number, and type of previous convictions.

7.13 Obviously given the events that have happened, this PSR has had no effect on the events that were shortly to tragically happen. The Panel accepts that at the time of assessment 'Medium Risk of Harm' was an accurate assessment. Of concern to the Panel is the weight given by the PSR author to the effects of alcohol on Marc's behaviour and the lack of any consideration to the possibility of the behaviour being rooted in Coercive and Controlling Behaviour. The PSR author's analysis of the causes of the offence mirrors that of the police. There was information available to the PSR author that should have alerted the officer to the risk of further harassment and potential Coercive and Controlling Behaviour.[18] as evidenced by the systematic destruction of her home, evidence of previous, and fear of further harassment by Marc. The PSR however makes no reference to domestic abuse, nor the presence of dynamic risk factors such as the perpetrator's acute substance abuse, mental health concerns and current suicidal thinking. This along with clear evidence of the recent separation which he opposed indicated that the victim was likely to be at considerable risk from Marc. The PSR author's recommendation of a Restraining

[18] https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship The Government definition also outlines the following:

Coercive behaviour is an 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 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.

Order did offer a degree of protection from physical contact but did not address the issue of his abusive attitudes and beliefs.

8.CONCLUSIONS

8.1 This Review has highlighted the following issues which have implications for future service delivery by the agencies involved. It is reassuring to see that the use of the DASH is clearly embedded within Hampshire Constabulary. However, this Review has highlighted several features in its use that undermine its value. Firstly, that Police Officers attending incidents in this case did not for some reason employ their own professional judgement as they are able to do in completing the DASH but allowed the responses of the victim to override the evidence available to them in crucial areas such as fear, harassment, Coercive and Controlling Behaviour and escalation. The reason for this is not clear to the Panel. The IMR from Hampshire Constabulary states that all Officers have received training relating to the dynamics of Domestic Abuse and Coercive and Controlling Behaviour. The panel believe that had the Officers responded to the observations they recorded in attending the incident, the risk assessment would not have been recorded as 'standard.' The disparity between incident and assessment and the Quality Assurance remarks do indicate the possibility of a 'numeric approach' being applied in this case.

8.2 Secondly from the files it seems that the PPN/DASH is not completed by the Officers attending but is completed later and by another Officer, as the first Officer felt a translator was needed but the second Officer felt Ana's English comprehension was sufficient. It must be noted that Ana was visibly shocked at the time, and this may have impacted on her use of English. This may explain the apparent discrepancy between the evidence recorded by officers in attendance and the DASH itself. In any event to the Panel, it appears a significant dislocation in the assessment process that will affect the quality and reliability of it. In addition, this case has clearly highlighted that the Quality Assurance process as it stands does not deliver the effective scrutiny and oversight that it needs to. The panel agree with the observations of the author of the Hampshire Constabulary IMR that the "quality assurer in this case failed to recognise an indicator as listed in the Standard Operating Procedure and categorised the case as Standard risk without referencing aggravating risk factors which are mentioned on the PPN1/DASH. They also failed to recognise the severity of the damage caused in this incident."

8.3 The arrest and remand in custody of Marc and obtaining a statement from the victim was done speedily and efficiently. Sadly, the time he was in custody was not well used and he was not interviewed and charged during this time which could have caused problems later, but fortunately did not. Immediately after Marc's release he breached his Bail conditions by approaching the area in which the victim lived, and the following day emailed her three times one of which was coercive and abusive. This did not result in a reassessment of the risk that Marc posed to Ana. This should

have been good practice in any event, but the failure to do so, and perhaps reassess Ana as at Medium Risk meant that she was not offered enhanced support and monitoring. The Panel know that this error was made by a student Police Officer. Mistakes are part of the learning process, and the same standards and expectations should not be made of those who are employed within a student role as is of others. The responsibility for this mistake lies either with the individual who was meant to be supervising the student officer or with Hampshire Constabulary for not ensuring effective oversight and supervision of the student.

8.4 The Panel is concerned that the PSR completed by the Probation Officer from Hampshire NPS mistakenly identified Marc's alcohol use and anger as the cause of the Criminal Damage offence he committed. As identified above the Panel believe this does not recognise the issue of separation and the evidence suggesting Coercive and Controlling Behaviour as indicated by the testimonies of the victims and the evidence of the Officers attending. It may indicate a lack of awareness of the dynamics of domestic abuse and Coercive and Controlling Behaviour. This is particularly evident in the failure of the system relying on an individual officer to complete an assessment with limited information. Had the Probation Officer had sight of the Body Worn Camera footage of the Criminal Damage they may have been able to fully recognise the level in risk to the victim caused by the separation of Ana and Marc, even if the fear evidenced to the officers at the scene was not made available to the PSR author. There is also the concern that the focus in terms of reducing Marc's risk may have been directed mistakenly towards anger and alcohol during his sentence, rather than his abusive attitudes and beliefs. The fact that Ana was currently at risk from Marc was addressed to a degree by the recommendation to impose a Restraining Order, but Marc's underlying attitudes and beliefs that had led to his offending were not.

9.LESSONS TO BE LEARNT

9.1 From the evidence available to the Panel there are clear lessons for Hampshire Constabulary in terms of administering and quality assuring the DASH. Firstly, attending officers' view of the incident, which from their records suggested Coercive and Controlling Behaviour were lost in the process of scoring the DASH. It is not clear whether this is an issue of confidence or reluctance to override the responses of the victim who may well have normalised to the abusive behaviour. Secondly, it seems that the DASH was completed by another Officer presumably that did not attend the original incident due to a mistaken belief Ana's use of English required an interpreter. The panel feel this can only reduce the accuracy of the DASH. It is also clear to the Panel that the Quality Assurance coordinators require further training, an issue already identified by the Child Abuse Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).

9.2 The failure to review the victim's risk following a further offence and Breach of Bail, all related to the same perpetrator and suggesting Coercive, and Controlling

Behaviour should be examined, and practice reviewed. The Panel are assured by Hampshire Police that a system has been put in place to ensure that following up on initial risk assessments occur later by the allocated investigating officer. These are now following a proforma to cover areas of risk and safeguarding at intervals or following a possible change/new offence.

9.3 The level of oversight of Student Police Officers and the level of responsibility they are personally expected to carry should be reviewed, with an expectation that more oversight and closer supervision of day-to-day practice is introduced. The Panel strongly believe Hampshire Constabulary should have reviewed the risk assessment of the victim and feel there were at least two trigger points which should have prompted such a review.

9.4 The Panel would also suggest that the case has highlighted a gap in the ability of the NPS to recognise 'and respond to Coercive and Controlling Behaviour within the PSR process.

9.5 The pressure on Hampshire Constabulary to release without charge was in part caused by poor planning during his period in custody and in part by the lack of interpreters.

9.6 It may be useful to explore the reasons for the Court's rejection of the application for remand in custody following the perpetrator's second breach of police bail so that lessons can be learnt and applied in similar future situations. Had the Court had sight of the extreme level of the criminal damage through either a written report or sight of the Body Worn Camera footage the likelihood of a remand in custody would have been higher.

10.RECOMMENDATIONS FROM THE REVIEW

10.1 That Hampshire Constabulary as a matter of urgency implement the further training identified by the Child Abuse HMICFRS report for the Quality Assurance coordinators (QA's) relating to the DASH. The Panel would suggest that either subject matter experts are used to undertake the quality assurance process itself, or if Hampshire Constabulary decide to continue using internal staff as subject matter experts that a process of assessment and a means of demonstrating competence in the role should be evidenced as a condition of taking that role. This could be achieved by training a cohort of QAs by a subject matter expert using a case study completed by the candidates to be assessed and marked using a model pro forma. Graduation to a QA role will be dependent upon completing that case study to a satisfactory standard.

V. The Panel have been assured that it was an exception that an Officer who was not at the incident completed the DASH. The Panel were assured that the use of 'professional judgement' in assessing DASH has been reinforced in training sessions, supervision, and on-line

messaging via Hampshire Constabulary communications systems. The Force has already developed a method by which good practice is identified and shared through the Force using a variety of methods to reinforce good practice.

VI. That all assessment documents completed by student officers with implications for the safety of adults at risk or children be either completed or quality checked by an experienced officer.

VII. That practice in completing DASH by officers be regularly scrutinised by the dip sampling of completed DASHs as part of supervision and appraisal.

VIII. Hampshire Constabulary assure Southampton Safe City Partnership that their provision of interpreters for victims and suspects for whom English is not their first language is fit for purpose.

10.2 That Hampshire NPS review the knowledge and awareness of its frontline staff in the dynamics of Domestic Abuse, focussing particularly on identifying and managing 'Coercive and Controlling' Behaviour, and the dynamic risk factors that indicate risk to victims. And that it provides learning opportunities for front line staff - particularly those involved in the assessment process both in the community and in custodial settings- those writing PSR's, assessment reports for Parole, Conditional Release etc to identify risk to victims from perpetrators as outlined in P12 HMPPS Domestic Abuse Policy Framework 2020.

10.3 The failure of Ana's employer to allow her colleagues and line manager to be interviewed by the Review is of concern. As a significant employer in the Southampton area, they have a relationship with the Local Authority. The Review recommends that the relevant business support departments in the City Council encourage all employers with whom they have a working relationship to adopt a Domestic Abuse Policy for their employees. In line with the best practice identified in the Department of Business, Energy, and Industry 'Workplace Support for Victims of Domestic Abuse' 2021[19]. All Employers can be directed to the Employers Initiative on Domestic Abuse [20] who provide at no cost advice and guidance on establishing a Domestic Abuse Policy and how to practically support staff facing these issues.

10.4 The Home Office share this DHR with the Ministry of Justice in light of information available at Bail hearings as our understanding is the file size for Body Worn Camera footage cannot be currently accommodated in the Courts IT system.

[19] https://www.gov.uk/government/publications/workplace-support-for-victims-of-domestic-abuse/workplace-support-for-victims-of-domestic-abuse-review-report-accessible-webpage
[20] https://www.eida.org.uk/

Southampton Domestic Homicide Review Action Plan

DHR reference: Ana

Action Plan following the death of: Ana

Action Plan produced by Kerry Owens

Date 15th June 2022

Updated 28th September 2023

This Action Plan is a live document and is subject to change as outcomes are delivered.

Recommendation	Scope of the recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
Recommendation 1: Hampshire Constabulary as a matter of urgency implement the further training identified by the Child Abuse HMICFRS report for the Quality Assurance coordinators (QA's) relating to the DASH. The Panel would suggest that either subject matter experts are used to undertake the quality assurance process itself, or if Hampshire Constabulary decide to continue using internal staff as subject matter experts that a process of assessment and a means of demonstrating competence in the role should be evidenced, as a condition of taking that role. This could be achieved, by training a cohort of QAs by a subject matter expert using a case study completed by the candidates to be assessed and marked using a model pro forma. Graduation to a QA role will be dependent upon completing that case study to a satisfactory standard.	Local	The Panel have been, assured it was an exception that an Officer who was not at the incident completed the DASH. All assessment documents completed by student officers with implications for the safety of adults at risk or children be either completed or quality checked by an experienced officer. That practice in completing DASH by officers be regularly scrutinised by the dip sampling of completed DASHs as part of supervision and appraisal.	Hampshire Constabulary	Established a Multi-Agency Public Protection Notice (PPN1) Scrutiny Panel. Insert Terms of reference. Quarterly Multi-Agency DA Scrutiny Panel established.	March 2021	9th March 2021 Terms%20of%20Reference%20-%20PPN May 2021
Recommendation 2: That Hampshire NPS review the knowledge and awareness of its frontline staff in the dynamics of Domestic Abuse, focussing particularly	Local	Clarify training offered to Probation Service Staff	HM Prison & Probation Service	Mandatory Domestic Abuse Training for all staff, delivered via eLearning and virtual classroom course.	Ongoing, rolling programme	Ongoing – every staff member completes training every 3 years.

Recommendation	Scope of the recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
on identifying and managing 'Coercive and Controlling' Behaviour and the dynamic risk factors that indicate risk to victims. Provide learning opportunities for front line staff - particularly those involved in the assessment process both in the community and in custodial settings- those writing PSR's, assessment reports for Parole, Conditional Release etc. to identify risk to victims from perpetrators as outlined in P12 HMPPS Domestic Abuse Policy Framework 2020.						 Probabtion DA Training.pdf
Recommendation 3: The failure of Ana's employer to allow her colleagues and line manager to be interviewed by the Review is of concern. As a significant employer in the Southampton area, they have a relationship with the Local Authority. The Review recommends that the relevant business support departments in the City Council encourage all employers with whom they have a working relationship to adopt a Domestic Abuse Policy for their employees.	Local	Briefing messages in relation to DA and Staff polices to be sent via the SCC 'social value through procurement' Supplier Portal (approx. 4000 suppliers) The same message will be sent via the Economic Development Team to local businesses / Chamber of Commerce	Southampton City Council	**Following message with local support distributed to approximately 7000 businesses.** **Domestic Abuse** Do you have a domestic abuse staffing policy? There are 2.3 million victims of domestic abuse each year, aged 16 to 74. Two thirds of whom are women, one third men. It takes place at all levels of society, regardless of social class, race, religion,	Ongoing rolling programme	Ongoing reminders will be sent during various times of year i.e., White Ribbon Day, International Women's Day, International Men's day.

Recommendation	Scope of the recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
				gender identity, sexuality or disability. As a socially responsible employer it is highly recommended that you have a domestic abuse staffing policy because the workplace is a place of safety and respite for many victims of domestic abuse. Colleagues and managers can often be the only other people outside the home that they talk to each day and are therefore uniquely placed to help spot signs of abuse. The Employers' Initiative on Domestic Abuse has a free toolkit to help you produce or refine your Domestic Abuse Policy as well as advice lines to support victims and offenders. Southampton City Council can also help with free advice for victims of domestic abuse along with providing helpline cards, leaflets and posters to employers.		

Recommendation	Scope of the recommendation	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
Recommendation 4: The Home Office share this DHR with the Ministry of Justice, in light of information available at Bail hearings as our understanding is the file size for Body Worn Camera footage cannot be currently accommodated in the Courts IT system.	National	Reviewing how Body Worn Camera footage can be shared within the court IT Systems.	Ministry of Justice			

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Kerry
Assistant Domestic & Sexual Abuse Co-ordinator
Adults Housing & Communities
Southampton City Council
17 Civic Centre Road,
Southampton
SO14 7FJ

28th November 2023

Dear Kerry,

Thank you for resubmitting the report (Ana) for Southampton Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in November 2023.

The QA Panel felt the report reflects an honest and transparent attempt to understand the events and agency responses in respect to Ana's death. There was consideration given to navigating barriers to engaging the family sensitively within the review and the statement provided by Ana's family gave insight into who Ana was as a person. The report is concise with fair and relevant recommendations, particularly the recommendation in respect to the employer preventing access to Ana's colleagues who may have contributed to the review.

The Home Office noted that most of the issues raised in the previous feedback letter following the first submission have now been addressed.

The following remain outstanding concerns and the CSP is requested to address these prior to publication:

- No additions have been made to the Equality and Diversity section. This does not acknowledge sex as a relevant protected characteristic or explore the gendered nature of domestic abuse.
- Whilst acknowledging that the words 'coercive and controlling behaviour' have been added to 4.17, there is no further exploration of coercive control, including economic abuse, as requested by the QA panel, represented.
- The following has been amended after QA feedback - *Ana stated to the officer completing the DASH "that after asking him to leave as she wanted to end the relationship due to 'his drinking and volatile behaviour, Marc had begun to*

smash Ana's belongings and the property". This reads as though it's a quote from Ana which it clearly is not. It would be better to just remove the quote marks.

- No information has been added about an inquest taking place.
- No dissemination list has been added.

Once completed, the view of the Home Office is that the DHR may be published.

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.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

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,

Home Office DHR Quality Assurance Panel