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.

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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 [1]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 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

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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 ttps://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.

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 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)[3] 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 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

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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/

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[4] 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 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. [5]
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

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[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.

[5] 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

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.

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 [6]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

[6] 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.’

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 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.[7] 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

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[7] 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.

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 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.

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.

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[8]. All Employers can be directed to the Employers Initiative on Domestic Abuse [9] 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.

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https://www.gov.uk/government/publications/workplace-support-for-victims-of-domestic-abuse/workplace-support-for-victims-of-domestic-abuse-review-report-accessible-webpage [8]

[9] https://www.eida.org.uk/