Domestic Homicide Review

Executive Summary

Portsmouth City Council

Community Safety Partnership

Report into the death of Betty

December 2019

Author – Dr Shonagh Dillon, LLB, DCrimJ

February 2022

1. Executive Summary

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

1.1 Outline of the Incident

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

1.1.3 Betty and Paul were in a relationship for approximately three years, the exact length of the relationship is unclear. From the start Betty's family and friends reported that Paul was 'controlling' and 'needy'. Betty had shown her friends and family members bruises; on one occasion these were bruises to her neck and on another occasion, she had bruises to her wrists. Betty told her friends that Paul was aggressive and possessive, and she wanted to leave him.

1.1.4 In October 2018 Betty had lost her mobile phone in the back of a taxi and since then she had been subjected to malicious communication from an unknown source. The source continued to release sexually explicit videos of Paul and Betty to everyone on Betty's contact list, this included her family and friends. In addition to these messages a Facebook page was also set up in Betty's name with sexually explicit photos of her.

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

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

1.2 Domestic Homicide Reviews (DHR)

1.2.1 The decision to undertake a DHR was made by Portsmouth City Council Community Safety Partnership (CSP) on 8th January 2020.

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

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

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

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

1.2.3 The purpose of a DHR is to:

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

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

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

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

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

f) highlight good practice

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

1.3 Terms of Reference

1.3.1 The over-arching intention of this review is to learn lessons from the homicide of Betty, and as a result change future processes and practice for potential and current victims of domestic abuse.

1.4 Independence

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

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

1.4.3 Additionally, all Independent Management Review (IMR) authors and Panel members were independent of any direct contact with the subjects of this DHR. None of the panel members were the immediate line managers of anyone who engaged with Betty or Paul.

1.5 Parallel Reviews

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

1.6 Methodology

1.6.1 The following agencies provided Independent Management Reviews to the panel with regards to either Betty/Paul or both:

- South Coast Ambulance Service (SCAS)
- Hampshire Constabulary
- Safeguarding Adults
- General Practitioners surgery (for Paul and Betty)

1.6.2 The panel consisted of the following members:

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

1.6.3 The chair would like to thank all professionals involved in this review, their time, effort and cooperation was exemplary.

Contact with Family and Friends

1.7.1 The chair contacted Betty's family and they were not able to contribute to the review. However, three of Betty's friends did speak to the chair and their input greatly illuminated the work of the panel.

1.7.2 Paul was contacted to take part in the review, but no response was received. Therefore, there was limited analysis from the perpetrator's perspective within the overview report.

1.8 Key Findings

1.8.1 Multi-Agency Training

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

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

- Domestic Abuse Stalking and Harassment (DASH) risk assessment training
- Homicide Timeline training[4]
- Trauma informed responses including ACES[5]
- Substance misuse and complex needs training for victims of domestic abuse
- Image based sexual abuse awareness
- Counter allegations

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

1.8.2 Routine screening

The use of routine enquiry for domestic abuse in health settings is sporadic across the board, but from the IMR records it appears that Betty was never asked the question by any health professional. The findings in this report point to a need to revisit routine enquiry for health professionals[6]. Whilst also being mindful of the intersecting needs and compounding factors of patients with complex needs.

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

[5] Adverse Childhood Experiences

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

1.8.3 National context

A recent series of events have placed male violence against women in the spotlight nationally since Betty's death. The Coronavirus pandemic during 2020, the murder of Sarah Everard[7] in early 2021 and the disappearance, and murder of Sabina Nessa[8] in September 2021, have led to a crescendo of calls for action and a focus from institutions on women's safety and the endemic levels of male violence against women and girls. It is worth repeating that a woman is killed every 4 days by someone she knows[9]. There is a real opportunity for a systematic overhaul by institutions and valuable reports and initiatives are now beginning to be rolled out[10].

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

1.8.4 Social Media

The crimes committed against Betty by Paul via social media platforms remained available to the public nearly two years after her murder, therefore Paul's actions were, however unwittingly, being emboldened by these platforms. The report author and chair of the panel spent some time with Betty's friends, and they alerted the panel to the social media pages. They were very distressed that Paul was still able to publicly shame Betty in this way. As a result, the chair undertook her own research into the issue. As part of that research the chair linked in with the charity, Report Harmful Content[11]. This charity was finally able to get the social media pages taken down. Betty's friends had repeatedly tried to report the issue to the social media companies' long after Betty was murdered. When they were removed, they were so grateful for this.

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

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

[7] https://www.bbc.co.uk/news/uk-england-london-58745581
[8] https://www.theguardian.com/uk-news/2021/sep/28/sabina-nessa-man-charged-murder-teacher-sabina-nessa-koci-selamaj
[9] https://www.femicidecensus.org/data-matters-every-woman-matters/
[10] https://www.justiceinspectorates.gov.uk/hmicfrs/publications/police-response-to-violence-against-women-and-girls/
https://www.theguardian.com/society/2021/nov/18/new-police-lead-on-violence-against-women-says-trust-has-been-broken
https://www.thetimes.co.uk/article/violent-crime-against-women-gets-the-same-status-as-terrorist-attacks-5tp2fn3pv
[11] https://reportharmfulcontent.com/?lang=en

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

This issue will be taken forward in the recommendations of this report as the panel acknowledge Betty will not be the only victim this has happened to and her loved ones will not be the only ones exasperated by the lack of interest from social media companies to honour her memory with dignity by taking the images down.

Aside from the aspect of dignity being of paramount importance, in the starkest sense, a crime was committed, and a conviction stands for it under UK law.

There is an opportunity to link these aspects of harm of domestic abuse victims to the discussions around Online Harms Bill[12]. However, campaigners are already raising concerns that the bill does not acknowledge or explicitly name violence against women[13]. This issue will be taken up in the national recommendations section.

1.8.5 Betty's friends (Victim Voice)

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

- Friend 3

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

Police and her GP should have asked her more. With people like Betty there needed to be more prodding and pushing and asking of questions[14], because she would never disclose off her own back. It would have been really hard for her to say what was going on for her with Paul, but I think if they had pushed and paid attention to her more it might have been different for her.

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

[12] https://commonslibrary.parliament.uk/research-briefings/cbp-8743/

[13] https://www.endviolenceagainstwomen.org.uk/experts-call-online-vawg-online-safety-bill/

[14] Professional Curiosity is paramount

- Friend 2

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

- Friend 1

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

'I keep going back to the day I was with her when she phoned the police and she was sobbing and even I felt like grabbing the phone and shouting "will you just listen to her", nobody was listening. Maybe that is the problem, Betty just wasn't listened too, she also wasn't ever asked.'

Following on from the recommendations received by the Home Office Quality Assurance Panel (see appendix B), the author of the review made contact with Betty's friends again to ask their views on what may have supported them to alerting her to services in order to get her support. One of Betty's friends explained that more information for family and friends would be welcome. The author has reflected this in the multi-agency recommendations and the CSP has agreed to scope the newly launched service, Findaway[15], which is specifically aimed at supporting friends and family of loved ones who are experiencing domestic abuse.

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

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

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

1.9 Recommendations

1.9.1 Single Agency Recommendations

There was a total of 13 single agency actions put forward by the IMR authors. These recommendations are presented below in their original format to ensure the integrity of the process. The panel have commented on each IMR recommendation and have made amendments where necessary. The final number of recommendations for the single agency action plan is 14, and the panel has suggested all single agency action plans are audited in 12 months to check they have been completed (see multi-agency recommendations 1.9.1).

1.9.2 South Central Ambulance Service (SCAS):

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

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

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

Recommendation 4: Audits of DA Safeguarding referrals for SCAS.

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

1.9.3 Hampshire Constabulary:

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

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

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

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

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

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

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

Panel comment - Recommendation 6: Hampshire Constabulary's crime data integrity scrutiny panel regularly check that reports of domestic abuse include reference to any counter-allegations. Hampshire Constabulary agreed to feedback provide regular evidence from the DA scrutiny panel to the CSP in relation to Portsmouth specific DVA data.

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

Panel comment - Recommendation 8: Feedback to the CSP on the effectiveness of training related to domestic abuse, including the effectiveness of SafeLives DA Matters training[16].

1.9.4 Safeguarding Adults (Portsmouth City Council Adult Social Care):

Recommendation 10: The IMR author provided the panel with information to evidence that the policy and procedure within the Adult MASH has now changed with hindsight of this case. Practice within the MASH has moved forward and contact would be made with a person referred with the same compounding issues of substance misuse as Betty. A member of the team will call a person to discuss/agree any action needed and to offer further support services.

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

Recommendation 11: Raise Awareness of the referral process for adults experiencing or at risk of Domestic Abuse. Training has been commissioned to promote Pan Hants guidance referencing raising safeguarding concerns.

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

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

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

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

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

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

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

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

Recommendation 14: In both Police and Probation services, domestic homicide reviews are dealt with by a central team whose role it is to compile IMR reports and liaise with review panels. This should be considered for health

services so that professionals can retain their specialist focus where it is needed most, and future panels can receive high quality reports.

1.9.6 Multi-Agency Recommendations:

1.9.7 The CSP will monitor a repeat audit for all single agency actions in twelve months to check all actions have been completed.

1.9.8 Universal health services revisit training and share information to health professionals regarding the importance of routine screening and asking the question of patients whether they are experiencing domestic abuse, as set out in the NICE guidelines[17].

1.9.9 Using Betty's story as a case study, Portsmouth's multi-agency domestic abuse practitioner's forum to consult with professionals on what needs to be done to change the culture within their own organisations and as coordinated partners in responding to domestic abuse. Particular attention will be given to unconscious/conscious bias with regards to Betty's case and how she presented in relation to both her multiple and complex needs and the care she was afforded.

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

- DASH risk assessment training
- Homicide Timeline training[18]
- Trauma informed responses
- Substance misuse and complex needs
- Image based sexual abuse awareness
- Counter allegations
- Professional curiosity
- Intersectionality[19]

1.9.11 The panel recommends individual agencies involved in this review consider the Femicide Census[20] recommendations in strategies and commissioning.

[17] https://www.nice.org.uk/guidance/qs116/resources/domestic-violence-and-abuse-pdf-75545301469381
[18] https://homicidetimeline.dreams-lms.com/
[19] https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1052&context=uclf
[20] https://www.femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf

1.9.12 The CSP considers whether to recommend the promotion of Report Harmful Content[21] Charity for specialist commissioned services responding to domestic abuse and sexual violence.

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

1.9.14 The CSP to consider the recently launched service, Findaway[22] which supports family and friends when they are concerned about a loved one who is experiencing abuse.

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

1.9.13 National recommendations:

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

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

[21] https://reportharmfulcontent.com/?lang=en
[22] https://www.wefindaway.org.uk/