DOMESTIC HOMICIDE REVIEW

Into the death of Finn (Pseudonym)

In July 2022

Executive Summary

Independent Review Chair/Author: David Warren QPM. LLB. BA. Dip. NEBSS

Review Completed: 18 May 2023

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Section One - The Review Process

1.1. This summary outlines the process undertaken by the Portsmouth Domestic Homicide Review Panel in reviewing the death of Finn (pseudonym), a Portsmouth resident.

1.2. Finn's partner, Laura (pseudonym) was charged with Finn's murder and was subsequently sentenced to life imprisonment with a tariff to serve a minimum of 23 years.

1.3. The following pseudonyms have been used in this Review for the deceased, the perpetrator (his partner), her child, her housemate, her friend and Finn's ex-partner, to protect their identities and those of their family members: Finn (the victim), Laura (the perpetrator), Alex, Laura's child, Marilyn, Laura's housemate and Vera her friend, Clare Finn's ex-partner. The date of Finn's death has been redacted for the same reason.

1.4. Finn aged 25 years of age at the time of his death, lived in Portsmouth in rented accommodation but regularly stayed over at Laura's home in Havant. Laura was 26 years of age and her child who lived with her was 5 years of age. All three were of white British heritage.

1.5. In July 2022, the Police notified the Safer Portsmouth Partnership about the circumstances of Finn's death.

1.6. On the 10 August 2022, the Chair of the Safety Portsmouth Partnership, after consultation with partners, decided to establish a Domestic Homicide Review (DHR) and the Home Office were notified on the 12 August 2022. An Independent Chair was appointed to conduct the DHR on the 11 October 2022. All agencies that potentially had contact with Finn, Laura or Alex prior to the point of Finn's death were contacted and asked to confirm whether they had involvement with them.

1.7. Seven of the fourteen agencies contacted, confirmed relevant contacts and were asked to secure their files.

Section Two - Contributors to the Review

2.1. The agencies contacted are:

- **Advocacy After Fatal Domestic Abuse (AAFDA):** This Charity was contacted to provide an advocacy service for Finn's family, but the offer was declined by the family, as they had already developed a strong bond with the Victim Support Homicide Case Worker who they wanted as their link with the Review.

- **Adult Safeguarding Hampshire County Council:** This Department had no relevant contacts with Finn, Laura or Alex. A Senior Manager was a DHR Member.

- **Children's Social Care Hampshire County Council:** This Department had relevant contacts with Laura and Alex and an IMR was completed. A Member of this organisation who is independent of any contact with Laura, Alex or Finn is a DHR Panel Member.

- **Stop Domestic Abuse:** This domestic abuse support service had no relevant contacts relating to Laura or Finn. A Senior Member of this Charity is a DHR Panel Member.

- **Hampshire and Isle of Wight Constabulary:** This Police Force had relevant contacts with Laura, Alex and Finn and an IMR was completed. A Member of this organisation who is independent of any contact with Laura, Alex or Finn is a DHR Panel Member.

- **Hampshire and Isle of Wight Integrated Care Board (ICB) re Laura, Alex and Finn's GP Practices:** A Senior Member of this organisation who is independent of any contact with Finn, Laura or Alex is a DHR Panel Member. The ICB instructed IMR Authors to provide IMRs on behalf of a GP Practice in relation to Laura and Alex. There were no relevant contacts regarding Finn. The IMR Authors had no previous contact with Laura, Alex or Finn.

- **National Probation Service:** This Department had no relevant contacts with Finn or Laura. A Senior Member of this Agency is a DHR Panel Member.

- **Portsmouth City Council Housing:** This Department had no relevant contacts with Finn or Laura. A Senior Member of this Agency is a DHR Panel Member.

- **Portsmouth Multi-Agency Risk Assessment Conference (MARAC):** The current Portsmouth MARAC Chair responded to a DHR Memorandum of Agreement, confirming that whilst there had been no referral to MARAC in relation to Laura, there had been one MARAC referral in 2018 relating to Finn's ex-partner in which Finn was the perpetrator of domestic abuse. The MARAC Chair provided an IMR report setting out her review of this referral. She had no previous involvement with Finn, Laura or Alex.

- **Solent NHS Trust:** This Trust had no relevant contacts with Finn, Laura or Alex. A Senior Member of this Agency is a DHR Panel Member.

- **Southern NHS Trust:** This Trust had no relevant contacts with Finn, Laura but submitted an IMR relating to Alex. A Senior Member of this Agency is a DHR Panel Member.

- **South Coast Ambulance Service:** This Trust had no relevant contacts with Finn, Laura or Alex.

- **Treetops Sexual Assault Referral Centre - Solent NHS Trust:** This service provided an IMR in relation to a contact relating to Alex.

- **Victim Support Homicide Service:** This Charity provided a Case Worker who acted as Finn's family link with the Review.

- **Yellow Door:** This Charity had no relevant contacts and has provided an independent domestic abuse expert to advise the Panel.

Finn's father, and ex-partner were in contact with the Review, via their Homicide Service Case Worker. After having had the opportunities to read the DHR Overview Report and the Executive Summary with their Homicide Care Worker, they provided a Tribute to Finn. They declined the invitation to the final meeting of the Review.

Laura was invited to contribute to the Review, both by her Solicitor and later by her Probation Offender Manager. She agreed to speak to the DHR Chair and provided information which assisted the review. She was provided with a copy of the Overview Report and her comments are included in that detailed report.

Section Three - The Review Panel Members

3.1. The DHR Panel consists of Senior Officers from statutory and non-statutory agencies who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the Members of the Panel had any contact with Finn, Laura or Alex.

3.2. The Panel Members are:

Name	Role	Organisation
Sayma Begum	Domestic Abuse Analyst	Portsmouth City Council
Rachel Windebank	Operations Director	Stop Domestic Abuse
Toby Elcock	Serious Case Reviewer	Hampshire Constabulary
Sarah Beattie	Head of Portsmouth & IOW Probation	Probation Service
Mark Fitch	Head of Local Authority Housing	Portsmouth City Council
Tracey Stovold	DA Expert Witness	Yellow Door
Michele Ennis	Designated Nurse Safeguarding Adults	ICB
Laura-Jane Osbaldeston	Designated Nurse Safeguarding Adults, Head of Vulnerable Adults	ICB
Kemi Awoyera	Designated Nurse Safeguarding Children	ICB
Kathryn Moloney	Specialist Adult Safeguarding Practitioner	Solent NHS Community and Mental Health Trust.
Susan Corley	Named Nurse, Safeguarding	‘Southern Health NHS Foundation Trust
Debbie Key	Strategic Partnership Manager	Hampshire and Isle of Wight Safeguarding Children Partnership

Andrew Jacobs	Team Manager, Children's Reception Team and Multi Agency Safeguarding Hub	Hampshire County Council

3.3. After an initial pre-meet, the DHR Panel met formally three times. The schedule of their meetings:

- 13 October 2022 - 10:00 to 11:30 (Pre-Meeting re ToR & Timescales
- 23 February 2023 - (Postponed due to protracted criminal proceedings to the 30 March 2023 - 09:30 to 12:00
- 4 May 2023 - 09:30 to 12:00

Section Four - Chair of the Review and Author of the Overview Report

4.1. The Chair of this Domestic Homicide Review is legally qualified and is an experienced Chair of Statutory Reviews.

4.2. He has no connection with the Safer Portsmouth Partnership and is independent of all the agencies involved in the Review. He has had no previous dealings with Finn, Laura or Alex.

4.3. He has an extensive knowledge and experience working in the field of domestic abuse and sexual violence at local, regional and national level. Between 2004 and 2011 he was the Home Office Criminal Justice Manager for the Government Office South West. Amongst his responsibilities were the funding and monitoring of the delivery of local services to address domestic violence and sexual crime. He was a founder member of both the South West Regional Safeguarding Children's Board and the Safeguarding Adults Board. He was also a member of a number of Central Government committees, including those relating to the development of Violence Against Women and Children policies, the national development and implementation of DHRs and the national funding of local domestic and sexual abuse services.

4.4. Since 2011 he has chaired numerous Statutory Reviews including Serious Case Reviews, Safeguarding Adults Reviews, Mental Health Homicide Reviews, Drug Related Death Reviews and Domestic Homicide Reviews across the country. He has been a keynote speaker at several National Conferences on domestic and sexual abuse, most recently on the particular issues facing Domestic Homicide Reviews in cases relating to Suicides.

4.5. For a number of years, he carried out voluntary work as the Chair of a substance abuse Charity and has provided pro-bono legal work for a refuge and its residents.

Section Five - Terms of Reference

5.1. Agencies that have had contacts with the victim, Finn, the perpetrator, Laura or her child Alex, should identify any lessons to be learnt from those contacts and set out provisional actions to address them as early as possible for the safety of future victims of

domestic abuse, particularly those who are vulnerable through mental health issues, alcohol and/or other substance misuse or gambling.

5.2. This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness and transparency, will be conducted in a thorough, accurate and meticulous manner.

5.3. Each participate agency's involvement with the following, from 1 May 2021 until the date of Finn's death in July 2022, as well as relevant contact prior to that period.

- Finn (pseudonym) who was 25 years of age at date of his death.
- Laura (pseudonym) who was 26 years of age at the time of Finn's death.
- Alex (Pseudonym) who was 5 years of age at the time of Finn's death.

5.4. Identify what lessons can be learnt from their interactions and how they will be acted upon, and what is expected to change as a result.

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

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

5.7. 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 the victim or manage the person who caused harm.

5.8. Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. This is a matter for Coroners and Criminal courts.

5.9. The Review will consider any other information that is found to be relevant, and which may contribute to a better understanding of the nature of domestic abuse and adult safeguarding.

5.10. The Review will also highlight good practice.

Section Six - Summary Chronology

6. The facts and background information obtained from the IMRs, chronologies, other reports, Finn's and Laura's family and friends are summarised as follows:

6.1. Finn and Laura had been seeing each other for approximately six months and they shared an interest in bondage, dominance, sadism and masochism (BDSM).

6.2. There was a CCTV camera set up in Laura's bedroom which recorded them having sex. Some weeks before Finn's death, Laura sent three edited clips of the footage to her friend Vera, suggesting Finn was violent to her before raping her. However, on checking the unedited footage, Police later found that this was part of consensual sex. Vera told the Police that Finn "had wanted the CCTV in the bedroom taken down because Laura was holding the videos she had, over his head because she kept on threatening to put them on Facebook and ruin his life." At Laura's trial, it was heard that when the CCTV recordings were viewed in context, "it contradicts the defendant's account of the three short video

clips she sent to Vera saying there had been non-consensual sexual violence by Finn on her. It also contradicted what Laura told the Police – that he had tried to attack her, and it was not the first time she had video footage of him raping and beating her." Laura has told the Review Chair that whilst their rough sex was consensual in the main, there were occasions when Finn went too far and although she screamed for him to stop, he did not do so. She said this was acknowledged by the trial Judge in his summing up.

6.3. On the night of his death, Finn was sleeping at Laura's house with her, in her bed. What triggered his death has not been fully established, but the Court accepted medical evidence that as there were no defensive injuries found on either Laura[1] or Finn, it would appear he was asleep when Laura cut his throat with a knife and then repeatedly stabbed him 17 times in the chest.

6.4. What has been confirmed, is that at 5 am on the day he died, Laura texted her friend Vera, stating she had a fight with Finn, and he had gone home.

6.5. At 7.45 am, the same day, Vera received a video call from Laura. They had a conversation and Vera was able to see Finn apparently dead on the floor with his throat cut. Laura disclosed to Vera that she had cleaned up and that the incident had occurred a few hours earlier.

6.6. Vera telephoned her mother, who advised her to contact the Police, she did this and when they attended Laura's home at 8.04 am, they found Finn deceased. On their arrival Laura had made a disclosure to suggest she was responsible and identified the knife used. The Officers found there were no defensive injuries on either Finn or Laura.

6.7. The motive was unclear however, the following information was known:

- Finn had inadvertently messaged a 13yr old girl on Facebook stating 'Hi' and that he had 2 children. The girl, informed Finn, she was 13 years old and told him to 'Get lost'. Finn deleted the girl, who was later found to be 17 years of age. The contact was recorded by Laura on her phone.

- Laura had a fixation with knives and had ornamental knives in her bedroom. She also slept with a dagger under her pillow.

- 1-2 weeks preceding the incident, Laura had a conversation with a friend when she stated "I could have killed him last night. I could have slit his throat'. A few days prior to the incident, she had a conversation with Vera, stating she wanted to have him beaten.

- Laura had installed CCTV throughout the house including the bedroom. Police reviewed the footage which contained violent sexual intercourse between Finn and Laura. This included Finn physically hitting Laura, however after examining the footage available before and after sex, this appeared to have been consensual, although Laura told the Review that he would on occasions go too far and not stop when she told him to do so.

- Laura had made an allegation of rape, by Finn, to Vera and sent her a video. This video again appeared to have been edited, based on the footage before and after the incident and included both parties having normal sex afterwards.

[1] Laura told the Review Chair that she had lots of bruises but because she is heavily tooted they could not be seen.

- The Police investigation revealed evidence of jealousy from both partners, in relation to each other's sex-partners.

- Police attempted to contact ex-partners of Laura however, they were not willing to provide a statement.

6.8. Laura confirmed she had a fascination with serial killers and had framed pictures of a number of infamous serial killers hung around her bedroom walls. At her trial it was noted that she collected books on infamous criminals and was an avid viewer of true crime documentaries. It was put to her at her trial that based on what she had learnt from these documentaries, she deliberately set up a false narrative of being abused by Finn and contacted her friend Vera in an attempt to create a false alibi and cleaned the crime scene.

6.9. The Pathologist in his report, identified that Finn's throat had been slit and that there was a total of 17 stab wounds to Finn's chest. The report highlighted the absence of any defensive wounds to Finn's hand or arms. He concluded that the cause of his death was catastrophic blood loss from a series of stab wounds to his neck and the front of his chest.

6.10. Laura was charged and subsequently found guilty of Finn's murder. She was jailed for a minimum of 23 years.

Section Seven - Key Issues

7.1. The Panel considered the following key issues stemming from this Review:

A. Whether Finn **being a male,** made it less likely that agencies would have considered that he could be a victim of domestic abuse or had been subjected to controlling behaviour by Laura. Whilst there is significant research that indicates that Professionals are less likely to consider a male being a victim of domestic abuse than a female[2], in this case no agency was aware of the connection between Finn and Laura. Children's Services acknowledges, with the benefit of hindsight, that an early visit to Laura's home to check on Alex's welfare (after Laura had reported the historic abuse of Alex by an 8 year old, 10 days prior to Finn's death), may have triggered questions about the environment Alex was living in, but this is tempered in the knowledge that whilst a visit was planned, it was not deemed urgent, as it was Laura who had acted responsibly in reporting the abuse and who had taken positive action with the other child's mother, to ensure that there would be no further sleepovers where the abuse had occurred.

B. The extensive research into **why women are violent towards their partners**. These focus on risk factors, mental health and substance abuse problems that are common amongst women who use violence, they include:

- Childhood trauma[3], *(In this case, there are reports that Laura had been abused as a child (see para. 14.3.1.)*

[2] E.g 'male victims have often been overlooked, and remained a "hidden" victim group, despite some researchers, and government statistics, evidencing their existence for decades" (Cook, 2009). "little is known about the nature of the incidents where men are recorded as victims and women as perpetrators" Who Does What to Whom? Gender and Domestic Violence Perpetrators Professor Marianne Hester.

[3] A review of research on women's use of violence with male intimate partners: SC Swan, LJ Gambone, JE Caldwell 2005

- Fear of violence, Women indicated that 35% of the time they used violence, was to retaliate for being emotionally hurt by their partners, while 20% of the time the motive was to retaliate for being hit first.[4] *(Laura had been the victim of domestic abuse in the past. Later she sought a DVDS disclosure on a previous partner who was involved in drugs. Whilst Finn and Laura had engaged in rough sex, it was evidenced, through her CCTV recordings, as being primarily consensual, however Laura pointed out to the Review that there were occasions when Finn went further than she wanted and refused to stop when she shouted for him to stop as he was hurting her. At her trial, she claimed that she stabbed Finn to protect herself, but this was discounted as it was proven that Finn had made no attempt to defend himself as he was 'probably asleep' at the time of the attack. (Finn had no defensive injuries which would have been expected if he had been conscious of the attack.)*

- Psychological Functioning, in particular depression, anxiety, substance abuse, and post-traumatic stress disorder have all been recognised as factors in relevant research studies. [5] *(Laura was diagnosed as suffered from PTSD, subsequent to having been abused as a child. It is noted that this was challenged during her trial. She was known to use controlled drugs and had self-reported having a high alcohol intake - para. 16.7.2.)*

- In Swan's study of women who used violence against male partners, it was found that 69% met criteria for depression on a screening measure. Almost one in three met criteria on a post-traumatic stress disorder screen. Nearly one in five were suffering from alcohol or drug problems and 24% of the participants took psychiatric medication. *(In this case, at Laura's trial, her defence team attempted to explain Finn's death by alleging:*

- *That Laura had been diagnosed with bipolar disorder and complex post-traumatic stress disorder (PTSD).*

- *That she had been sexually abused as a child, suffered nightmares and flashbacks, and had self-harmed "for years".*

- *That she had an interest in serial killers. Laura explained she had a "dark and twisted sense of humour", liked watching murder documentaries, and said the pictures of serial killers on her bedroom walls were aimed to "shock people."*

- *Laura claimed they had both consumed alcohol and cocaine. That she was 'angry, upset, and confused 'after finding a message on his phone from a 13 year old girl and this tipped her over the edge.' She said, she had threatened to put one of the videos, in which she said she was raped, online and go to the Police. "It made him really angry, his whole demeanour and body language changed, you could see it in his eyes, he was raged. He grabbed me by the throat and pinned me to the bed on the headboard.") Laura's use of camera technology to threaten Finn with is not uncommon. Since Covid, the Domestic-violence charity Refuge has reported that*

[4] Abused women or abused men? An examination of the context and outcomes of dating violence Follingstad, Wright, Lloyd, & Sebastian

[5] Patterns in Relationship Violence Among African American Women: Future Research and Implications for Intervention: John k. Williams, Gail E. Wyatt, Hector F. Myers, K. Nicole Pressley Green & Umme S. Warda.

more than 70% of those it provides support to have reported tech-related abuse within a relationship.

The Panel acknowledged that having been brought up in an environment where she was abused at home and due to her deafness, bullied at school, combined with her early substance abuse, she was attracted into a number of short-term chaotic relationships where violence and abuse was the norm. This gave her little opportunity to experience or understand healthy relationships. Notwithstanding, her fascination with violence and her collection of weapons was not typical and should not be considered to be an excuse for her violent murder of the sleeping Finn.

C. Laura and Finn's reported indulgence in **BDSM[6] ('rough sex**') which on occasions went beyond the bounds of consent, was highlighted in Laura's court case. It was acknowledged during the trial that it typically involves one partner taking on a more dominant role during sex, while the other is more submissive but can stray further than agreed.

According to a 2016 study, nearly 47% of women and 60% of men have fantasised about dominating someone in a sexual context. The same study found that BDSM sex was slightly more prevalent in couples on the LGBTQ spectrum, but researchers otherwise determined that BDSM sex was practiced across different ages, genders, and ethnic backgrounds. (cf. Joyal & Carpentier). While many reported BDSM fantasies, only 7.6% identified as BDSM practitioners. Another study found similar rates of BDSM related fantasies, with over half of all participants reporting at least one BDSM-related fantasy (Joyal, Cossette, & Lapierre,

D**. Lack of reportin**g the controlling behaviour and threats to Finn.

- It is clear that Laura made a number of threats to harm Finn, by claiming he raped her, by talking of having him beaten, and stating she could have stabbed him while he slept. Yet her friends treated her remarks about wanting to hurt Finn, as 'just talk' and never reported them to the Police or any other agency. This resulted in agencies having no reasons to predict that Laura would murder Finn, and therefore have little opportunity take any action that would have prevented his death.

Section Eight - Conclusions

8.1. The Review Panel assessed the Individual Management Reviews and other reports as being thorough, open and questioning from the viewpoints of Finn. The Panel is satisfied:

- That all agencies that participated in the Review used the opportunity to review their contacts in line with the Terms of Reference of the Review.

- That those organisations that conducted all of their contacts with Finn, Laura or Alex in accordance with their established policies and practice, have no lessons to learn.

- That the other organisations have used their participation in the Review to properly identify and address key lessons that can be learnt from their contacts with Laura, Alex or Finn.

[6] BDSM is a term used to describe sex that involves dominance, submission, and control. The practice often known as 'rough sex'.

8.2. The Panel has after discussion, accepted the recommendations made by the individual agencies and Local Partnerships and has added further cross agency recommendations that include reminding professionals that males can be victims of domestic abuse and controlling behaviour, and to encourage the public to report domestic abuse. These actions which address the needs identified during the Review, should improve the safety of domestic abuse victims in Portsmouth.

Section Nine - Lessons to be Learnt

9.1.1. This Review has identified positive practice including a clear approach to supporting victims of domestic violence using the IDVA service and the positive approach by Police in prosecuting offenders of domestic abuse.

9.1.2. The Author has identified that in the main, risk assessments have been completed accurately, however there has been regrading incorrectly on occasion by the MASH coordinators.

9.1.3. Many of the incidents that the IMR Author commented upon, were prior to the scoping window of April 2021 to July 2022, and training and processes has changed over the last five years. (See paras 16.5.7. 16.5.10. and 16.5.11)

9.2. **Hampshire County Council Children's Services:**

9.2.1. There is a need to document enquiries considering if there are any unknown adults in the home and record the open discussions with parents and other professionals.

9.3. Hampshire and IOW Integrated Care Board

18.3.1. **Effective Practice -** GP took concerns seriously and approached for advice to appropriate agencies. The GP referred the child, Alex, immediately to Social Services to highlight concerns for child sexual abuse

9.3.2. It has been identified with hindsight, that there were indicators of vulnerability and mental health needs, and that windows of opportunity were presented for further professional curiosity. This highlights the importance of triangulation of the holistic presentation of both the individual and the wider family to inform domestic abuse risk assessment and care planning.

9.3.3. An interagency referral (IARF) to MASH should be made when there may be a suspicion of Child sexual abuse.

9.3.4. Patients may not engage with primary care services for prolonged periods of time, despite being vulnerable and/or having unmet needs. This means that primary care, are reliant on the information they receive from other agencies to inform risk assessments.

9.4. Treetops SARC Hampshire & IOW (SARC)

9.4.1. The Review highlights a lack of knowledge amongst practitioners regarding the HIPS Guidance manual on when, where or how to refer a victim of a sexual assault.

9.5. Safer Portsmouth and Stop Domestic Abuse

9.5.1. Members of the Public, who witness or hear of domestic abuse taking place or being planned are often unsure of what action, if any, they should take.

9.5.2. It is recognised, that males are less likely to report incidents of domestic abuse and in addition, professionals may not always consider males as possible victims of domestic abuse and controlling behaviour.

9.5.3. Information sharing between Agencies was identified as being wanting on occasions.

Section Ten - Recommendations

The DHR panel's recommendation and up to date action plan at the time of concluding the Review on 4 May 2023 are detailed in the template below. After publication of this report, Safer Portsmouth Partnership will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
There is an apparent lack of public understanding on the course of action to take if a third-party, witnesses or hears an incidence of domestic abuse occurring. This should be addressed with a Portsmouth wide campaign involving family, friends and communities to raise public awareness on what to do if they are aware of domestic abuse taking place to victims who may be male or female.	Local	The Partnership will utilise the following campaigns: 1."This Love" https://www.facebook.com/watch/?v=724390662501961 / https://twitter.com/SaferPortsmouth/status/1637760613949612033 2.Ask ANI: https://www.gov.uk/guidance/ask-for-ani-domestic-abuse-codeword-information-for-pharmacies 3. UK Say No More Portsmouth spaces listed here Safe Spaces Locations - UK SAYS NO MORE	Safer Portsmouth Partnership and Stop Domestic Abuse	To include 20 day White Ribbon Campaign in November 2023		**Ongoing**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
Domestic abuse training for practitioners should include:- a) other training resources, such as trauma-informed approach, homicide timeline, child sexual abuse, and engaging with perpetrators of domestic abuse. In addition: a) a reminder that males can be victims of controlling behaviour. b) that technology including CCTV can enable abuse and digital stalking. c) that BDSM ('rough sex') can mask domestic abuse.	Local	Partner agencies to ensure that domestic abuse policies and training needs to include males as possible victims.	Safer Portsmouth and Stop Domestic Abuse.	To be discussed at Partnership meetings.	Ongoing	**Ongoing**

Social Workers should evidence in their notes that they have shown professional curiosity when responding to allegations of abuse relating to children, for example enquiring about any unidentified adults visiting the home in accord with the Unidentified Adults toolkit.	Local	Reissue HSCP toolkit unidentified adults across Children's Services Department. This toolkit promotes professional curiosity in considering who else may be significant within the household.	Hampshire County Council Children's Services.	Unidentified Adults toolkit reissued.		**May 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date

Review of the Ghost patient process.	Local	Scope and develop Ghost patient process.	Named GPs / Hampshire ICB.	Confirm definition of Ghost Patient. Scoping data regarding the prevalence of Ghost patients. Risk assessment for Ghost patients developed. Ghost patient response pathway developed.	Sep 2023	
Domestic abuse training for primary care, with a focus on professional curiosity, routine enquiry, indicators of abuse and thinking family.	Local	Designate and third sector commissioner training for practice to include direct learning from DHR.	HIOW ICB Designated Nurse GP Surgery Hampshire and IOW ICB System	Scoping/business case development. Project Planning	Sep 2023	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
		Designated Nurse DA Portfolio Lead, to develop training opportunities business case, to include commissioning of training offer.		Programme implementation.	Sep 2023	
Implementation of the ICB recommended Primary Care Domestic Abuse and Sexual Violence Toolkit.	Local	Designate and third sector commissioned training for practice to include direct learning from DHR. Designated Nurse DA Portfolio.	HIOW ICB Designated Nurse GP Surgery Hampshire and IOW ICB System	Scoping/business case development. Project Planning. Programme implementation.	Sep 2023	
Family approach reviewed within practice vulnerable patient meetings.	Local	Develop a template for implementation at vulnerable patient meetings.	HIOW ICB Named GP Hampshire and IOW ICB System	Proforma developed. Proforma shared with PCNs and practice safeguarding leads.	August 2023	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date

Operation Amberstone Lead may wish to audit investigation times to ensure investigations are being conducted diligently and expeditiously.	Local	None.	Hampshire & Isle of Wight Constabulary	Tri-Force data arrangements provide insight into the timeliness of investigations at various stages. Key Performance Indicators have been set to improve timeliness of investigations. This is subject to thematic review on a monthly basis at the Amberstone Performance meeting as well as within the VAWG WESSEX arrangements. NFA scrutiny panels have been raised attended by Police, CPS and advocacy partners exploring the		**Dec 2022**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
				efficacy and timeliness of decisions. Senior District Crown Prosecutors (SDCP) and RASSO Supt scrutiny of cases that have entered the CPS. The scrutiny occurs after 90 days and may include cases that have only reached the Early Investigative Advice stage. There are multiple reports that are examined on a monthly basis for the purpose driving investigative activity and improving communication		

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
				with CPS Forensic examination of digital devices specifically in relation to Rape are prioritised within the Phone Examination Unit.		