Domestic Homicide Review

Portsmouth Community Safety Partnership

Executive Summary of the Report into the homicide of Lee January 2021

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1. The Review Process

1.1 This summary outlines the process undertaken by the Domestic Homicide Review Panel to review the homicide of a 26 year old male Lee, who lived in Portsmouth. Lee was killed by his 24 year old brother Ivan. Both brothers were white British.

1.2 Pseudonyms are used to protect the identities of the deceased and their family members.

1.3 The decision to undertake a DHR was made by the Portsmouth Community Safety Partnership in consultation with local specialists on 3rd February 2021. The Home Office was informed of this decision on 4th February 2021. An Independent Chair for the Review was then appointed at the first panel meeting on 11th March 2021. IMRs were requested by 8th May 2021 but the DHR process was then suspended pending the trial of Ivan since the information in the IMRs may have been used in the trial. IMRs were requested again on 20th July 2021 to be returned by 25th August 2021. Agencies were advised to implement any learning arising from these as soon as possible. Six meetings of the Panel were held between March 2021 and February 2023. Panel meetings were arranged in this way to enable members of the Panel also participating in other ongoing DHRs to be able to dedicate their time to all Reviews. There was a professionals reflective meeting in June 2022.

1.4 Agencies that potentially had contact with Lee and Ivan were contacted and asked to confirm whether they had contact with them.

2. Contributors to the Review

2.1 Each of the following organisations submitted an IMR or information for the review.

AGENCY	CONTRIBUTION(S)
Portsmouth IDVA Project	• Individual Management Review • Chronology
Portsmouth Children and Families Services	• Individual Management Review • Chronology
National Probation Service	• Individual Management Review • Chronology
Stop Domestic Abuse	• Individual Management Review • Chronology
North Harbour Medical Group	• Individual Management Review • Chronology
Society of St James	• Individual Management Review • Chronology
Hampshire Police	• Individual Management Review • Chronology
Portsmouth City Council Housing Services	• Individual Management Review • Chronology

Hampshire & Isle of Wight Fire & Rescue Service	• Individual Management Review • Chronology
GP North Harbour Medical Group	• Chronology

3 Review Panel Members

3.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Lee or Ivan. It also included a senior member of the Portsmouth Community Safety Unit and independent advisors from domestic abuse services.

3.2 The members of the panel were:

Organisation	Role on Panel
Portsmouth IDVA Project	Panel member
Portsmouth Children and Families Services	Panel member
National Probation Service	Panel member
Stop Domestic Abuse	Panel member
North Harbour Medical Group	Panel member
Society of St James	Panel member
Hampshire Constabulary	Panel member
Portsmouth City Council Housing Services	Panel member
Hampshire & Isle of Wight Fire & Rescue Service	Panel member
Hampton Trust	Panel member
Hampshire and Isle of Wight Integrated Care Board	Panel member

4 Author of the Overview Report

4.1 The Chair and Author of this report, Patrick Hopkinson, is an independent adult safeguarding consultant, a Safeguarding Adults Review author and a Chair of Domestic Homicide Reviews.

4.2 Patrick Hopkinson is experienced in adult safeguarding and provides training, consultancy and service development services nationwide for the statutory and voluntary sectors. He was the Head of Adult Safeguarding for a London Borough, contributed to regional and national policy development and was the adult social services strategy lead on Violence Against Women and Girls (VAWG). Patrick has completed Modules 1 and 2 of the Home Office online Domestic Homicide Review training

4.3 Patrick is an author of reviews following suicides and homicide-suicides. Patrick is an Associate of the Local Government Association and lectures, and supervised research, at the Institute of Psychiatry, Psychology and Neuroscience for Kings College, London.

4.4 Patrick Hopkinson has no link with any of the organisations involved in this DHR.

5 Terms of reference

5.1 Background

5.2 This DHR examines the circumstances leading up to the death of Lee in January 2021. Lee was killed by his brother Ivan. Ivan was sentenced to 6.5 years for Manslaughter on 16th July 2021.

5.3 This review, as commissioned by Portsmouth Community Safety Partnership, considers the involvement and actions of the different agencies with Lee and Ivan since 29th September 2018. In addition, the review also examines past events to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking this holistic approach, the review seeks to identify appropriate solutions to make the future safer.

5.4 Domestic Homicide Reviews 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 relationship, or;

b) A member of the same household as herself;

With a view to identifying the lessons to be learnt from the death.

5.5 The purpose of a DHR is to:

- 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.

- 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.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce

the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

5.6 The Domestic Abuse Act (2021) defines abusive behaviour as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional or other abuse

5.7 For the definition to apply, both parties must be aged 16 or over and 'personally connected', which means that they

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

5.8 Controlling behaviour is defined as, "*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*".

5.9 Coercive behaviour is defined as, "*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.*

5.10 Key Lines of Enquiry

5.11 The Review Panel agreed that the purpose of the review was to be specific in relation to patterns of domestic abuse and/or coercive control, and was to explore:

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5.12 **Awareness of and response to domestic violence and abuse and coercive control**

5.13 Was there any indication or escalation of the risk of domestic violence and abuse and were these indicators recognised and responded to? Were Lee and Ivan open to MAPPA, MARAC any programmes or interventions for reducing the risk of domestic violence and abuse?

5.14 Were any domestic violence and abuse tools such as DASH, DVPN, Right To Know and Right To Ask (Clare's Law) and were any ancillary orders considered or used and if so, how effective were these assessed to have been at the time

5.15 Were there any opportunities for professionals to routinely enquire as to any domestic abuse experienced by Lee and Ivan that were missed?

5.16 Were staff working with Lee and Ivan confident about what service provision is available for domestic violence and abuse locally?

5.17 Were there any barriers to providing or seeking support with domestic violence and abuse? What were they? How might these be overcome?

5.18 **Information sharing and multi-agency working**

5.19 Was there any collaboration and coordination between any agencies in working with Lee and Ivan individually and as a family (and with any children) and comment on its effectiveness.

5.20 Health and social care needs

5.21 Were there any causal or consequential links between any unmet social care needs or mental health problems/ substance use and domestic violence and abuse?

5.22 Were there any recent changes in Lee or Ivan's mental health and well-being that may have affected their behaviour?

5.23 Individual and family factors

5.24 Were there any cultural perceptions, beliefs or stereotypes, equality and diversity or deprivation factors that may have influenced how agencies engaged with Lee and Ivan or how they assessed risk? How effectively was professional curiosity practiced?

5.25 Organisational factors

5.26 Did the context (i.e. demand management, response to Covid-19 etc) in which each agency was working at the time with Lee, Ivan or their family have any impact of the type of interventions made and on their effectiveness?

5.27 Learning and practice development

5.28 What lessons can be learnt in respect of domestic violence and abuse and/or coercive control, how it can affect adults, children and young people and how agencies should respond to any impact?

5.29 Are there any training or awareness raising requirements for professionals or victims of domestic violence and abuse that are necessary to ensure a greater knowledge and understanding of the services available?

5.30 Methodology

5.31 The Review involved the analysis of a combined and annotated multi-agency chronology of involvement, IMRs (Independent Management Reviews conducted by managers in the relevant agencies but who were not personally directly involved in the case) and questions for professionals. A practice learning event was held to engage front line practitioners and first line managers who had contact with, or made decisions about, Lee, Ivan or their wider family and to explore key events and themes with them. The findings from this event have been incorporated in the DHR report.

5.32 Due to ongoing COVID-19 restrictions, all meetings were held virtually. These restrictions, their impact on the capacity of the participating organisations and the suspension of the DHR to allow for the criminal justice process to be completed led to the review taking more than six months to complete.

5.33 Lee was a 26-year-old white British man whose first language was English. Lee did not have any known overt religious beliefs or affiliations. There are no references to Lee having children. Lee had mental health difficulties and drug and alcohol problems.

5.34 This review is of the homicide of a man, Lee, by another man, Ivan. Lee and Ivan were brothers. Consequently, this review considers fratricide (the homicide of a sibling). Domestic abuse, and domestic homicide more specifically, is frequently regarded as gendered: women are more likely to be the victims of domestic violence and abuse than men are, men are more likely to be the perpetrators of domestic abuse than women are. However, the definition of domestic abuse and domestic homicide includes familial abuse and homicide.

5.35 Ivan is a white British man who was 24 years old at the time. Ivan did not have any known overt religious beliefs or affiliations. Ivan had two children. He was also known to have mental health difficulties.

5.36 There is no evidence that Lee and Ivan were directly or indirectly discriminated against by any agency based on the nine protected characteristics under the Equality Act 2010. It is likely, however, that Lee and Ivan's mental health difficulties might have increased the risk of domestic violence and abuse between them (and in their family) and might have decreased awareness and recognition of it by agencies whilst at the same time increasing barriers to receiving support.

6 Summary Chronology

6.1 Lee and Ivan's predominant contact with services which might intervene in domestic abuse was with the criminal justice system. Apart from contact with the police, Lee, Ivan and their mother rarely sought help from services for the problems they experienced. Instead, services were only involved in response to individual incidents rather than in a systematic way. There was limited contact with domestic abuse intervention and support services, and what contact there was concerned the impact of Lee and Ivan's actions upon partners and ex-partners' children rather than on each other. The services involved were PIP (Portsmouth Independent Domestic Advocate Project) which provides support to victims of domestic abuse assessed as at high risk, and Stop Domestic Abuse, which provides support for those assessed as at medium risk of domestic abuse. Support for those at a standard risk is provided by Victim Support.

6.2 Lee had 20 convictions for 36 offences. Almost all of Lee's convictions involved aggressive behaviour, with the exception of two convictions for breaching Community Orders. Lee said that all of these were the result of his use of alcohol and cocaine. There was a pattern of offending towards partners and family members, including his father and mother and less so to strangers.

6.3 Ivan had a history of antisocial behaviour, substance use and violence committed within the familial setting both as a victim and a perpetrator since he was a child. Ivan had two convictions for three offences, comprising two offences against the person and one offence of theft. These were not domestic abuse related and the previous offences occurred when Ivan was a minor and in school.

6.4 The risks that Ivan posed towards partners were harassment, threats of criminal damage, general discord and antisocial behaviour, verbal abuse and threats of harm. Concerns about risks to family members were similar and there was evidence of wider volatility within familial relationships. There had been a sustained history of Hampshire Police call outs since 2014 and a pattern of mutually abusive verbal and physical incidents with Ivan being both a perpetrator also a victim.

6.5 Lee and Ivan were frequently involved in violent or threatening incidents with their mother, Rita. Lee was often considered to be more likely to a perpetrator rather than a victim than Rita or Ivan but there were incidents in which Ivan behaved in a violent or threatening way to both Lee and Rita.

6.6 Lee was in prison for over nine months between 2018 and 2021 on four occasions. Two of these were for short periods for breaches of conditions but on Lee was recalled to prison on 6th October 2020 and was released on license in January 2021. Lee was collected from prison at 10am by family members, including Ivan.

6.7 During the car journey from prison, Lee and Ivan argued about Ivan having received £3,400 in a tax rebate or furlough scheme claim that was due to have been paid to Lee. Ivan had also taken out a £50,000 Bounce Back loan in Lee's name. Ivan had used

this money to buy the car in which he had collected Lee from prison and to gamble. Ivan, however, denied that he had done this. It appears that the argument passed, and that Lee and Ivan drank cider, took cocaine and visited friend's homes.

6.8 At 12.30pm, Lee and Ivan parked outside a block of flats. Lee appears to have been driving and in the process of parking had bumped into another car. Lee and Ivan got out, Ivan checked the damage but then was physically attacked by Lee. They argued and witnesses reported that Lee threatened to kill Ivan, who ran back to the car and collected a knife. They both challenged each other, and Ivan stabbed Lee in the chest with the knife, severing his pulmonary artery. Before collapsing, Lee kicked in one of the windows on Ivan's car.

6.9 Ivan telephoned 999 but said nothing. Witnesses also telephoned 999. Paramedics arrived but were unable to save Lee's life. Ivan was arrested whilst hiding in a building site claiming that he was scared for his own life.

7 Key issues arising from the review

7.1 Lee and Ivan were brothers and met the definition of "related" in the Domestic Abuse Act 2021 and the requirement to undertake a DHR. The involved agencies, however, struggled to know how to respond to the domestic abuse within Lee and Ivan's family. Lee and Ivan, their mother Rita and others were all at times both victims and perpetrators of domestic abuse and clear coercion, control and power relationships were absent. Lee and his family did not easily fit within the standardised national model which identifies a victim and perpetrator and provides support using different intervention models for each. This was compounded by the added complications of many men not recognising and/or not asking for support when they are victims of DA.

7.2 The DHR panel acknowledged that there are many different typologies of behaviours that fall under the definition of domestic abuse. It considered, however, that processes for identifying and responding to these different typologies remain limited.

8 Conclusions

8.1 The purpose of this review was to consider

8.2 **Awareness of and response to domestic violence and abuse and coercive control**

8.3 Domestic violence and abuse was recognised as a factor in Lee's family and in Lee and Ivan's relationships with partners and ex-partners. It was not clearly and consistently recognised in Lee and Ivan's relationship with each other, although violent incidents were known by the police, for example, to have taken place between them. There was also less clear recognition of the effects of coercion and control in family relationships.

8.4 Similarly, domestic violence and abuse was assessed and interventions offered to Lee and Ivan's partners and ex-partners, and assessments were made of risk to children. These were reported to the appropriate arrangements including MARAC and Domestic

Abuse support services. The risk of violence between, or the effects of coercion and control on Lee and Ivan were not explored. The only domestic violence intervention offered to Lee was withdrawn when he was recalled to prison. It is unclear whether or not Lee would have accepted this intervention.

8.5 There were some specific problems in sharing information between probation officers. There was a missed opportunity to impose license restrictions limiting Lee's contact with family members upon his release from prison in January 2021. These would have been appropriate given the history and pattern of violence within Lee's family. License restrictions, however, must be enforced and there was evidence of slow responses to these by the Hampshire Police when Lee breached them.

8.6 Given the complexity of the family relationships, in which Lee, Ivan and Rita and others were all at times both victims and perpetrators of domestic abuse, a multi-agency "Think Family" approach might have helped to better understand family dynamics and might support intervention and risk assessment. This approach builds the resilience and capabilities of families to support themselves and recognises that individuals rarely if ever exist in isolation and that whole-family approaches are often necessary to meet individual and family wide needs. The core principles of the "Think Family" approach are that practitioners:

8.6.1 Consider and respond to the needs of the whole family; including poverty, drug and alcohol use, domestic abuse and mental health difficulties of everyone in the home (including frequent visitors) in all assessments and interventions.

8.6.2 Work jointly with family members as well as with different agencies to meet needs.

8.6.3 Share information appropriately according to the level of risk and escalating concerns if they are not otherwise being responded to.

8.7 Such an approach may have led all agencies involved to greater consideration of Lee's family circumstances and may have helped to identify motivating and protective factors including friends and other relatives. A Family Approach has been developed by Portsmouth City Council which could facilitate this.

8.8 **Information sharing and multi-agency working**

8.9 Appropriate information sharing and multi-agency processes were used such as MARAC and MAPPA but despite this, not all risks were captured or fully understood. Multi-agency working tended to be episodic and MARAC processes, for example, were stopped when Lee returned to prison. Given the nature of Lee's offending, the family history of domestic abuse and the short term and cyclical nature of Lee's imprisonment, release and recall, a more consistent approach between the probation and the prison service might have been useful.

8.10 **Health and social care needs**

8.11 There was a recognition that Lee, and Ivan and Rita in particular, had mental health needs but this does not appear to have influenced the approaches taken with them. It is likely, and was to extent recognised, that violence and abuse had been a long term factor in the family and had impacted on Ivan's and very likely Lee's childhoods.

8.12 There are strong evidential, as well as logical and intuitive, links between child sexual abuse, physical abuse and trauma and the experience in adulthood of mental health problems, excessive use of drugs and/ or alcohol, self-neglect and chaotic and abusive personal relationships. These traumatic events in childhood are often referred to, somewhat euphemistically since the term barely captures their extremely disturbing nature, as adverse childhood experiences (ACE).

8.13 ACEs include growing up in a household with someone who has mental health needs, misuse substances or has been incarcerated in the criminal justice system. They include exposure to child maltreatment or domestic violence and also losing a parent through divorce, separation or death.

8.14 Exposure to such ACEs has been associated with poor health outcomes including substance use, mental ill-health, obesity, heart disease and cancer, as well as unemployment and continued involvement in violence.

8.15 Importantly, the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. Significantly, people who have been exposed to multiple ACEs are more likely to die at a young age from natural causes, suicide or homicide.

8.16 There is also considerable practice and research evidence that people with a history of trauma struggle to engage with the services that try to help and support them. Lee (and Ivan and Rita) were in irregular contact with multiple agencies, which struggled to engage with them. A trauma-informed approach to supporting families with a significant history of domestic abuse and other offending may also be helpful.

8.17 **Individual and family factors**

8.18 The relationship between Lee and Ivan was not explored and instead the focus was on the risk they posed to others. This lack of curiosity also extended to a lack of attention to the family more widely. This is partially explained by the transient nature of Lee's (and other members of his family's) contact with services and their reactive responses to him. Longer term approaches, less contingent on eligibility criteria or legal mandates might be more effective when working with families where domestic violence and abuse seems to be so entrenched that it appears to be a part of life.

8.19 **Organisational factors and barriers to practice**

8.20 The contacts with Lee and his family, partners and ex-partners took place within the context of Covid-19 restrictions. There is some evidence that this affected the actions of some services and led to reduced contact with Lee by the probation service.

8.21 The services in contact with Lee and his family also tended to work in silos and there is a need to improve communication and interagency working to identify risks of domestic abuse in wider family relationships. This requires the use of multi-agency approaches that are embedded in practice so that they become the default way of working rather than exceptions. When working with complex families the standard approach should be one of partnership between all the agencies involved and this should be used to identified other organisations that need to be involved.

9 Lessons Learned

9.1 Short custodial sentences, often because of recall to prison, disrupt community-based interventions and are sometimes unhelpful for developing consistent multi-agency approaches (see recommendation 1)

9.2 There is a need for community based domestic abuse approaches to remain involved for people who have been recalled to prison for short sentences. De-registration from MAPPA and withdrawal from MARAC due to prison sentences means that community awareness and management is interrupted. As a result, an opportunity to notify the National Probation Service and the CRC of the risk that Ivan posed to Lee was missed. (see recommendation 2)

9.3 There is a need for greater integration of MARAC process with prisons so that a less episodic approach can be used to managing offenders (see recommendation 2)

9.4 Concerns about domestic abuse expressed by ex-partners should be shared at MARAC meetings and the extent that there is risk to a current partner or to family members should be assessed (see recommendation 2).

9.5 Release from prison should be considered as a transition and risks should be assessed and actions taken which could include, for example, the use of non-contact conditions in situations where there is intra-familial and intergenerational domestic abuse and where family members pose risks to each other. Similarly, address checks should be made prior to discharge from prison to identify if people who have a history of domestic abuse will be living together and if so, alternative accommodation should be sourced. This may require information sharing between agencies including the police and the Probation Service (see recommendation 3).

9.6 *The police have identified that PPNs should be completed consistently so that they capture risks to children (or adults who are made vulnerable by their circumstances and their health and social needs) and* that where alleged offence do not meet the

evidential threshold of police action, it does not mean that further action cannot be taken by other organisations and risks should still be assessed. These are part of on-going work by Hampshire Constabulary and their internal training and auditing processes.

9.7 Portsmouth Safeguarding Adults Board has introduced a MARM (Multi-Agency Risk Management Meeting) for adults with multiple needs who do not meet the adult safeguarding threshold for a statutory enquiry under section 42 Care Act 2014 and can be called on an ad hoc basis and can be held with the appropriate agencies (from between two to many) as required and held virtually in order to facilitate swift responses. Multi-professional work should continue between MARM meetings and progress reported on at the next meeting (see recommendation 2).

9.8 This may have been a useful forum for further discussion of, and planning for, how to respond to Lee, Ivan and Rita's needs and for coordinating health and social care interventions with domestic abuse and criminal justice interventions. The MARM was introduced in 2016 and is currently being reviewed and greater integration with, for example, MARAC and MAPPA could be included in this (see recommendation 2).

9.9 There is a need to consider a multi-agency "Think Family" approach when working with families where there is a persistent history of domestic violence and other offending. Co-ordinated multi-agency interventions should be the standard approach in these circumstances. The impact on children of domestic abuse is well research and identified as a factor on a child's development. Interventions that support positive parenting and safety might help to reduce the risk of domestic abuse. Portsmouth City Council has developed a Family Approach which could facilitate this (see recommendation 4).

9.10 As this review demonstrates, people who perpetrate domestic violence are sometimes victims of it too and a binary distinction between perpetrator and victim is sometimes misleading. There is a need to consider how people who behave in a violent and abusive way are supported to change their behaviour and longer term interventions may be useful in this. The recently updated Portsmouth Domestic Abuse Strategy (2020 - 2023) has five priorities; two of which are in relation to working with adults who are being abusive or using unhealthy behaviours: priority C is "Challenge and support those who use abusive or unhealthy behaviours" and priority D is "Hold to account those who use coercive control and violence". There is an associated action plan with the aim to improve the partnership response to more complex cases of domestic abuse (see recommendation 3).

9.11 Similarly, where perpetrators are also victims and where violence and abuse is a factor in inter-familial relationships but where there is no coercion and control or imbalances of power, the models for responding to domestic violence and abuse are sometimes inappropriate and restorative family based approaches may need to be considered (see recommendation 3).

9.12 Fratricide is relatively uncommon and there is research evidence (for example, Hine et al, 2020) that the risk of fratricide is often not recognised. In the case of Lee and Ivan, threats and violence between them and other family members and sometimes others were frequent features, which may have further obscured the risks that Ivan posed to Lee. There is a need for greater awareness amongst professionals of the risk factors and potential warning signs identified in this Domestic Homicide Review and for professionals to consider the risk of fratricide in situations like this and for fratricide risk to be discussed in MARAC meetings (recommendation 2 and 6)

9.13 There is a need to recognise and respond to reduced help-seeking by men and to offer emotional support in addition to practical or behavioural interventions. (recommendation 2 and 6).

9.14 Lee experienced considerable housing instability. There is substantial, as well as intuitive, evidence that the well-being of both individuals and families is substantially affected when the need for satisfactory housing is not met. Without stable and secure housing, other efforts to support people with their mental health needs, their drug and alcohol use, their dangerous behaviours are unlikely to be successful. Tackling housing insecurity is fundamental to facilitating stability on which other interventions can be built.[1] As part of the local authority statutory duty to provide safe accommodation, Portsmouth City Council Housing is writing a Domestic Abuse policy and is considering DAHA (Domestic Abuse Housing Association) accreditation. This will include an improved understanding of the complexities of meeting multiple needs.

9.15 There is a need to support practitioners, through supervision, leadership and multi-agency interventions, to reduce feelings of inevitability, fatigue, hopelessness, "burn out" and associated reduced expectations for change, when working with people who present cyclical, repeating and seemingly unresolvable, challenges that appear to be part of their way of life. The Violence against Women and Girls Strategy being undertaken by the Portsmouth City Health and Wellbeing Board is considering four pillars. One of these is in relation to organisational and cultural change and includes how services support both their service users and their employees in relation to domestic abuse. This will be considered further in work to implement the strategy.

[1] According to the United Nations (UN) Committee on Economic, Social and Cultural Rights, satisfactory housing consists of: legal security of tenure; availability of accessible services, facilities and infrastructure; habitability; accessibility (e.g. access to employment, health services, schools, etc); cultural adequacy; and affordability. There is a strong interrelationship between mental health and homeless including insecure housing, such that housing can be considered to be "foundational" to good mental health and wellbeing (Padgett, 2020).

10 Recommendations

10.1 The multi-agency recommendations are:

10.2 **Recommendation 1** The Probation Service should investigate how to strengthen the links between MARAC and domestic abuse processes for those serving short periods in prison so that opportunities for interventions are not lost.

10.3 **Recommendation 2:** The Portsmouth Safeguarding Adults Board should strengthen the MARM processes and practice so that the MARM increases the likelihood of achieving positive outcomes for victims of domestic abuse in those case which might fall outside of other arrangements such as adult safeguarding, MAPPA or MARAC.

10.4 **Recommendation 3:** The DHR Author, the Portsmouth City Council Head of Service for Partnerships and Planning and the Portsmouth City Council Strategy and Partnership Manager to write to the Home Office to advise that homicides in the absence of coercion and control and power relationships do not fit easily within in the DHR process and definition of domestic abuse and for this to be considered when reviewing the guidance on DHRs.

10.5 **Recommendation 4:** Each agency involved in this review should audit their approaches to cases of inter-familial domestic abuse to identify the extent to which adaptable models are used that respond to victims who have previously been identified as perpetrators and vice versa. The results of the audit could be used to identify further developments in, amongst others, processes, protocols and training.

10.6 **Single agency recommendations:**

10.7 **Recommendation 5**: The Probation Service should ensure that OASYS (Offender Assessment System) captures risks arising from arguments and problems with money and gambling and that these are recorded as possible triggers of further offending.

10.8 **Recommendation 6**: Stop Domestic Abuse to review its training in relation to use of professional judgement for MARAC referrals

10.9 **Actions already completed:**

10.10 The Hampshire Constabulary MASH training sergeant has delivered training to frontline staff and specialist teams on the completion of PPNs to capture the risk of domestic abuse to children. This has included targeted work with student cohorts and has become business as usual. In addition Hampshire Constabulary is scrutinising the quality of PPNs, which is leading to improvement in quality and is training police staff on the new PPN1 form.

10.11 Training has now been harmonised to cover risk and vulnerability. The Resolution Centre has rolled out physical training across all 3 teams to refresh and standardise practice This includes PPN1 training to help focus on adult vulnerabilities. This training

is now able to be delivered to new staff in cohorts, which provides continued focus on best practice. Domestic Abuse champions provide oversight.

10.12 Hampshire Constabulary holds a domestic abuse learning panel meeting every two weeks across districts. Domestic abuse Champions will conduct thematic reviews on a district basis. These will seek to address specific issues within districts and identify areas of need. Op Dawn (peer to peer supervisor reviews) are being undertaken across the Hampshire Constabulary, specifically looking at the themes identified for the district. Action covered under Bronze DA Plan 2022-2023.

10.13 In November 2021 the definition of a domestic incident was updated on the Hampshire Constabulary intranet to "Family members is defined as mother, father, son, daughter, brother, sister, grandparents, in-laws or step family". The new and revised definition of domestic abuse, from the Domestic Abuse Act 2021, explains personal and family connections. This is included in the DA FPPs currently being revised and will be available on the DA Hub.

10.14 All frontline Hampshire Constabulary officers and investigators have had presentation briefings which included the importance of ensuring all children are checked on and spoken to. The risk to any child or vulnerable adult is being recorded in PPNs and ensuring 'Home, Health and Happiness' is recorded, so the appropriate referrals can be made by the MASH.

10.15 Hampshire Constabulary has created a brief guide for easy access by officers to DASH risk grading criteria which has been published on their intranet. The Domestic Abuse Learning Panel has identified that the MASH has tended to grade risk as higher than guidance dictates when it should be graded lower in 20% of referrals overall.

10.16 Hampshire Constabulary has introduced a revised Force Performance Profile (FPP) on the role and responsibility of both the Controller and the attending officer, to ensure that information provided during a call and CSPECCS answers are relayed to attending officers, while at domestic incidents. Domestic Abuse crimes and incidents can only be closed by Supervisors. All Domestic Abuse crimes and incidents must have a specific Domestic Abuse review by a Domestic Abuse champion or Supervisor, which needs to consider risk and PPN1 completion, if there is a need for ancillary orders or disclosures and whether the investigation has had sufficient victim focus. There is a monthly audit on compliance and quality to highlight any failings in the process.

10.17 Hampshire Constabulary Supervisors now complete rolling three-weekly reviews of all crimes held by investigators so any crime held will have continued supervisors guidance and more rapid intervention in investigation direction. Ninety-six day reviews are also completed and there is a dashboard to support this.

10.18 In 2021 there were 14 Hampshire Constabulary cross-command Continuing Professional Development (CPD) dates focusing on the identification of stalking behaviours and accurate crime recording. This has been supported by victim advocacy and health professionals who specialise in Stalking. CPD has also been supported by

The Hollie Gazzard Trust which was created following the murder of 20-year-old Hollie Gazzard in 2014 by an ex-partner. Set up by her parents, along with her sister, the charity helps reduce domestic violence through creating and delivering programmes on domestic abuse and promoting healthy relationships to schools and colleges. A 12 month-licence for the Gazzard presentation has been purchased to support future CPD. Additionally a Stalking Analysis has been commissioned to better understand the problem profile in Hampshire. Stalking and harassment is now going to be included in the new PPN1 form.

10.19 Hampshire Constabulary is monitoring families with complex needs where additional risk management is required. Such families are identified through daily overnight searching and from performance/ITD products. Additional scrutiny and tasking is already in place for Domestic Abuse offences through the district's Domestic Abuse Coordinator, who has been in post since November 2021. An additional agenda item relating to prison releases has been added to the monthly TPM to flag individuals or complex situations which need greater risk management.

10.20 The Hampshire Constabulary Senior Leadership Team will also explore, with the heads of the local adult and children's services, the means to raise/request complex strategy meetings when needed. These meetings will then have the required risk management documentation detailing the risks identified, with suitable partnership ownership, governance and accountability. It is anticipated that risks and mitigation will be documented in either an 3RM model (Recognise, Reduce, Remove, Manage) or RARATS (Reduce, Avoid, Remove, Accept, Transfer, Share).

10.21 Hampshire Constabulary has given presentation briefings to all frontline officers and investigators, explaining Restraining Orders, Non Molestation Orders and breaches, including bail conditions. A Task and Finish group is monitoring consistency and compliance with Non-Molestation Orders/bail conditions.