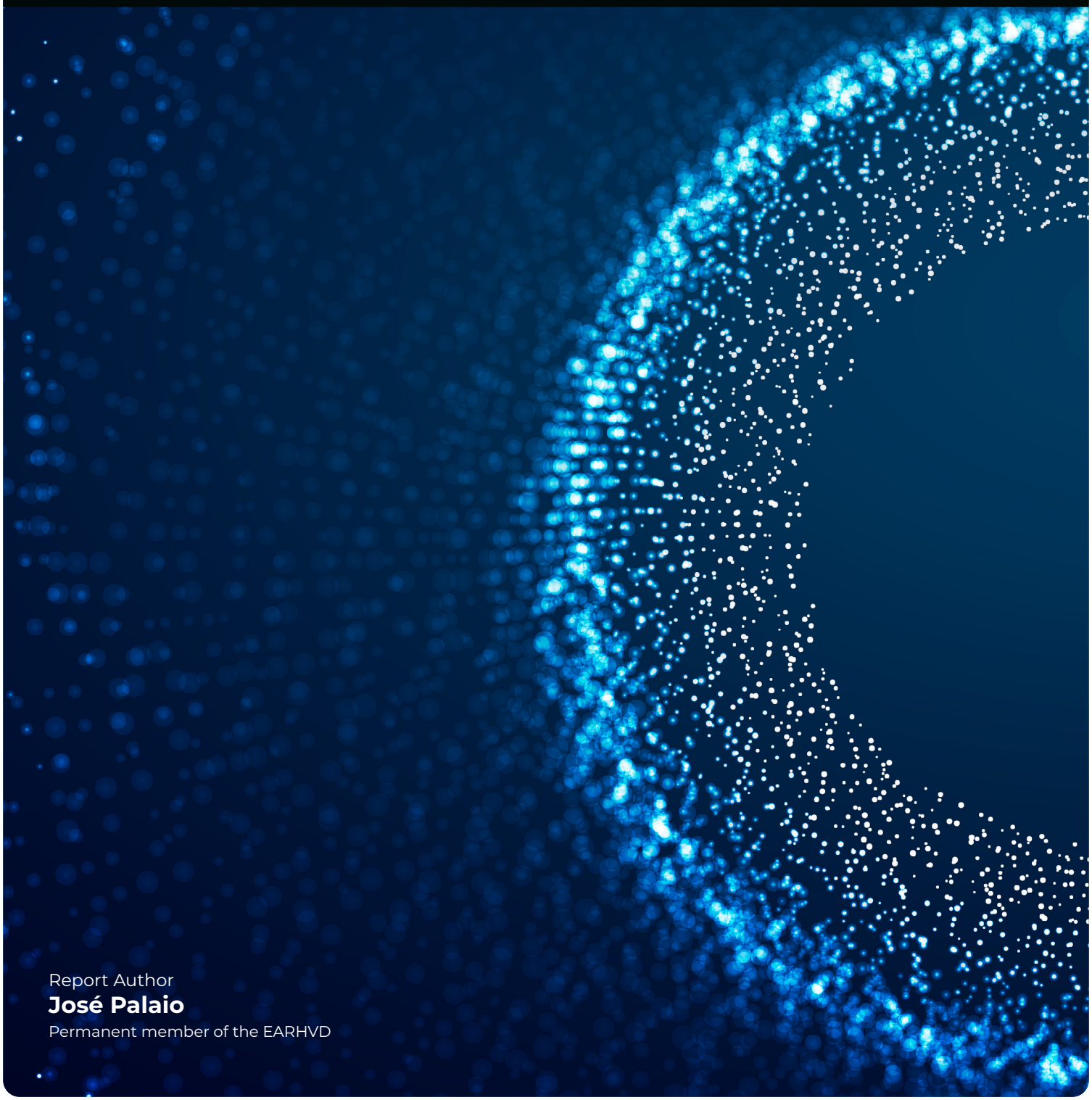
Case: **2/2018-JP**

EARHVD
Equipa de Análise Retrospetiva de Homicídio em Violência Doméstica

FINAL REPORT

Domestic Homicide Review



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Domestic Homicide Review

01.

Identification of the case

CHAPTER

01.

Identification of the case

The present report concerns the review of case no. (...), with legal proceedings in the MP from (...), having a decision to terminate the respective criminal proceedings been taken on the 30th January 2018, due to demise of the perpetrator, in accordance with the provisions of articles 127 and 128, no. 1, both from the CP. Consequently, all procedures were dismissed due to being legally inadmissible, in accordance with the provisions of article 277, no. 1 of the CPP.

The homicide in the domestic violence context subject of review in this report occurred between 11.00 am on the 3rd July 2017 (date when the victim was last seen) and 12.00 am on 3th July 2017 (date in which the body was found).

The review procedure was initiated on 19th July 2018, and the Team (EARHVD) was constituted by its permanent members and a non-permanent member representing the police force territorially competent in the area where the homicide occurred, in this case the 1st Sergeant of the GNR, António Paulo Vieira Pinto.

The present report aims at:

- Analyse the information collected with a view to a more complete understanding of the circumstances of time, manner and place in which the facts occurred, the behaviour pattern of the victim and the perpetrator and the factors that influenced them, as well as the responses from all the services, entities and organizations involved.

- To carry out a technical and scientific diagnosis of the use, rejection or alienation of the

- actions to prevent domestic violence and to protect its victims.

- To draw conclusions which may allow the implementation of new preventive methodologies.

- To draw up recommendations for the improvement of procedures, in order to reduce the risk of other occurrences of the same nature.

Domestic Homicide Review

02.

Characterisation of the parties

CHAPTER

02.

Characterisation of the parties

According to the provisions set forth in article 10, no. 4 of the Ministerial Order no. 280/2016, of 26th October, the diploma that regulates the procedure for domestic violence homicide review, were eliminated in the review and subsequent report all data allowing the identification of all parties in the judicial process. The victim will be recorded as **A** and the perpetrator as **B**.

2.1. Characterization of A - Victim

- Gender: Female
- Date of birth: (...) 50 years old
- Marital status: Married to the perpetrator
- Nationality: Portuguese
- Profession: Housewife
- Employment situation: Unemployed
- Municipality of residence: (...)

2.2. Characterisation of B – Perpetrator

- Sex: Male
- Date of birth: (...) 53 years old

- Marital Status: Married to the Victim
- Nationality: Portuguese
- Profession: Explosive's operator
- Employment situation: Employed
- Municipality of residence: (...)

Domestic Homicide Review

03.

Documentation obtained and analysed

CHAPTER

03.

Documentation obtained and analysed

Under the terms of article 4-A, numbers 4 and 5 of Law no. 112/2019, of 16th September (legal regime applicable to the prevention of domestic violence, protection and assistance to its victims - LVD), the review focused on the following elements:

3.1. Documentation contained in the already identified enquiry

- Report/Complaint of 5th July 2017
- Enquiries
- Legal Order to close the enquiry

3.2. Other documentation and information collected

From the information requested via all members of the EARHVD has been obtained additional relevant data, from the areas of health, justice, internal administration, citizenship and equality, and social security. **A**'s sister and **B**'s sister were also heard.

Domestic Homicide Review

04.

Information collected

CHAPTER

04. Information collected

4.1. Facts set out in the legal order closing the enquiry no. (...) – summary

- On the 5th July 2017, at 12.28 pm, **A**'s body was found on the bed, in the bedroom of the house where she lived, already in an advanced state of decay, with signs of aggression.

- On the bedside table of the said room a handwritten paper was found which read "I didn't want to do this I went to the hill to end my life. **B**".

- That same day, on a hill about 100 metres from the house, the body of **B**, **A**'s husband, was found hanging from a tree by a rope, with an aluminium ladder next to the tree trunk.

- **A**'s body was found in an advanced state of decay and with traumatic lesions on the face, thorax, lumbar region, left upper limb and both lower limbs. They were not the cause of death and presented characteristics compatible with having been inflicted during life.

- The toxicological examination carried out on peripheral blood taken from **A**´s body showed a blood alcohol level of 3.17 grams per litre.

- From the combination of all data, the medico-legal autopsy report on the corpse of **A** concluded the hypothesis of homicide by mechanical asphyxia caused by thoracic compression.

- From the combination of all data, the medico-legal autopsy report on the corpse of **B** concluded that the death was due to mechanical asphyxia by extrinsic con-

striction of the neck, all consistent with the possibility of suicide by hanging.

- The toxicological examination carried out on the peripheral blood for ethanol on the corpse **B**'s corpse showed a blood alcohol level of 0.22 grams per litre.

- The investigation indicated that "[the] couple often had arguments because of alcohol use by the deceased [**A**] (which is consistent with her blood alcohol level at the time of her death)".

- No evidence has been found to indicate that third parties entered **A** and **B**'s home, where **A**'s body was found.

- In view of the circumstances in which **B** was found, everything points to him having taken **A**'s life and then committed suicide by hanging, as he had announced in the manuscript that he left on the bedside table in the bedroom of the house where **A**'s body was found.

4.2. Relevant information for the review process

4.2.1. Previous inquiries

There are three reports from which information can be gathered related to events in which **A** was a domestic violence victim and **B** was the perpetrator.

Although it is not a report on domestic violence, we should also mention another report, dated from 28th March 2011, which originated the Enquiry no. (...), corresponding to a report of **B**'s disappearance, submitted by his nephew, in which the following is reported:

- B would have argued with **A** inside their residence.

- It was not the first time that such an argument situation had occurred.

- **B** had already confided in her that he could not take it anymore and that any day he would something wrong.

- **A** was a regular alcohol user, which would have led **B** to leave the house.

- On 30th March 2011, **B** was found at his residence.

4.2.1.1. First report, for events that occurred on 13th June 2014

The complaint report was based on facts that occurred on 13th June 2014, which led to the Enquiry no. (...) of the MP from (...), corresponding to the report prepared by the GNR, after having received a communication regarding "a domestic violence situation between spouses". The following facts are described in the report:

- On the 13th June 2014 GNR carried out a police intervention in the house where **A** and **B** resided, being present both of them and a 26-year-old daughter. The daughter has a mental disorder and is cared for in an institution for people with disabilities and went to her parents' home fortnightly.

- **A** and **B** were intoxicated, and **A** said that **B** had beaten her violently all over her body, causing several bruises, that she has already been the target of several assaults, lives in deep fear because **B** is threatening to kill her. All of this was witnessed several times by her daughter.

A did not wish to benefit from the status of victim and did not attend the medical/legal examination to which she was summoned. **B** has not been formally accused.

The complaint states that urgent intervention is needed because "both spouses stated that it was normal to have a high number of alcoholic drinks is a normal, daily habit, and that subsequently leads to all violent situations".

On 2nd December 2014, the MP ordered the enquiry to be dismissed due to insufficient evidence of **B** having assaulted **A**, stating in the grounds of the legal order that:

- **A** did not intend to provide further statements or undergo a medical examination, which demonstrated a lack of interest in pursuing the case and a refusal to co-operate in the investigation and in establishing truth;

- No means of evidence was indicated and no other evidential steps useful or relevant to establish the truth don't appear to be present.

4.2.1.1.1. Information provided by the Commission for Citizenship and Gender Equality

According to the following information provided by CIG, **A** benefited from follow-up during the course of this enquiry:

- **A** attended a supporting centre of the National Support Network for Domestic Violence Victims (RNAVVD) in 2014.
- She was suffering severe physical and psychological abuse from **B** and did not want to abandon her husband or leave the house.
- Due to excessive alcohol abuse, she was referred to a support addictions service, where she joined the PRI Programme (a specific intervention programme within addiction behaviours aiming at reintegration). Her first appointment was on 19th June 2014, and the last she attended was on 6th December 2014.

4.2.1.2. Second report, for events that occurred on 21st November 2015

The second complaint was based on facts that occurred on 21st November 2015 leading to Enquiry no. (...) of the MP form (...). The GNR report presented the following facts:

- On 21st November 2015 GNR went to the house where **A** and **B** resided, due to B allegedly kidnapping and assaulting **A**.
- **A**'s sister was near the couple's house and said she had been unable, for two days, to get in touch with her, who would have been kidnapped by **B**. **A**'s sister informs that **A** suffers constant and violent aggressions and has a broken arm. She also stated that **A** confessed, when **B** was not present, to being constantly assaulted by **B** and life-threatened several times, fearing for her life.
- **A** denied these facts, stating that she had broken her arm falling down the stairs. She and B stated that, in order not to be constantly bothered by her family, they intentionally broke their mobile phone card and bought a new one.
- The neighbours reported that they had never witnessed aggression, but that they heard **A**'s cries of distress from time to time, as well as several arguments between them, with **A** showing up with bruises all over her face on several occasions. But that "nobody took sides because they are both alcoholics".

In the enquiry, **A**'s sister did not give a statement, benefiting from the right provided for in article 134 of the CPP. **A**, in turn, claimed that she had never been physically or verbally assaulted by **B** and that "they have fights like any other couple".

On 22nd April 2016, the MP ordered the case to be dismissed for insufficient evidence of the facts that **B** was suspected of, on the following grounds:

- **A** denied having been physically or verbally assaulted by **B** and her sister reported not wish to testify.
- No other eyewitnesses or other or other means of proof was presented.
- Therefore, the chances of the reported being convicted at trial are slim, if not non-existent.

4.2.1.3. Third report, for events that occurred on 28th June 2016

The third report was based on facts that occurred on 28th June 2016 leading to the Enquiry no. (...) of the MP from (...), having **A** filed a complaint against **B** for domestic violence. The report describes the following facts:

- On 28th June 2016, **B** assaulted **A** with punches and kicks to the legs and face, having grabbed a towel and tried to suffocate her, stopping just before she fainted. The aggression was due to the fact that **A** was not at home when **B** arrived.
- After the assaults and after dinner, **B** told her that she was a "whore", "cow", a "bitch", and that she wouldn't sleep in bed with him, that it was better to lie on the floor.
- **A** informed that she had been suffering from aggression from **B** since they were married 29 years ago, and that he regularly made life threats if she left him, and she feared that he would carry out the threats.

On 29th June 2016, GNR assigned the victim status under article 14 of the LVD. On the same date, implemented the risk assessment through the RVD-1L form, whose only source of information was the victim, and 11 risk factors were identified, resulting from the affirmative response to the following questions:

- No. 1 - Has the offender ever used physical violence against the victim?

- No. 3 - Has the offender ever attempted to strangle (try to choke), suffocate, or drown the victim or other family member?
- No. 5 - Was medical attention required after any assault and/or did the injuries compromise the victim's normal daily activities or those of other family members?
- No. 7 - Has the offender ever used/ threatened to use any kind of weapon against the victim or other family member, or has easy access to a firearm?
- No. 8 - Do you believe that the offender is capable of killing you, or having you killed (are you convinced that he is really capable)?
- No. 9 - Has the offender ever tried to or threatened to kill the victim or other family member?
- No. 10 - Does the offender stalk the victim, intentionally intimidate her, display excessive jealousy and tries to control everything the victim does?
- No. 12 - Has the offender ever attempted or threatened to commit suicide?
- No. 14 - Has the offender ever been the subject of previous criminal complaints?
- No. 18 - Has the victim been separated from the offender, attempted to/manifested an intention to do so (in the past/next 6 months)?
- No. 19 - Does the victim or any member of the household have special needs and/or support from others?

The level of risk for the victim was classified as high and the following protective measures were identified:

- Reinforce with the victim the importance of distancing herself from the offender and consider the possibility of moving away, for example, by going to a shelter home, or to the home of a relative/friend/ trusted colleague in the first days (while the offender is not yet arrested).
- Reinforce personal protection guidelines with the victim (safety plan).
- Refer the victim to a support centre that will assign her to a shelter home.

- Provide information to the victim about support resources.
- Establish regular contact with the victim.
- Ensure that the victim is accompanied when removing her possessions from the house.
- Accompany the victim, when requested, to places such as court, hospital and social security.

On the same date, **A** was notified by GNR to undergo a medico-legal examination on that same day, at 2.00 pm, but she did not attend. She was referred to social security services in order to be sheltered, but **A** refused this referral. Social Security subsequently found accommodation for her at a sister's home.

On 19th August 2016, GNR proceeded to question **A**, who did not provide statements, benefiting from the right provided for in article 134 of the CPP. And on that date a risk assessment re-evaluation of was implemented using the RVD-2L form, whose only source of information was, once again, the victim. This assessment identified 8 risk factors, given that the above-mentioned factors 5, 7 and 8 were no longer part. The level of risk was, therefore, classified as medium and the protective measures were as follow:

- Reinforce with the victim personal protection guidelines (safety plan).
- Reinforce the information on support resources.
- Establish regular contact with the victim.

There is, however, no information in the records about the specific implementation of the protection measures and/or on their follow-up.

On 23rd August 2016, GNR questioned **B**, who declared he did not wish to make any statements.

On 5th September 2016, the MP ordered the closure of the enquiry due to insufficient evidence against B, on the following grounds:

- **A** did not attend the medico-legal examination and stated that she did not wish to give a statement.

- **B** also did not make a statement and no witnesses were identified regarding the facts reported or other means of proof.

- The last risk assessment report resulted in a medium risk.

- There is, therefore, reasonable doubt as to the authorship of the facts. Consequently, the defendant has reduced, if not non-existent possibilities of being convicted.

4.2.1.3.1. Information provided by the Institute of Social Security

On 29th June 2016 GNR activated LNES requesting shelter for **A**, informing that:

- On 28th June 2016 there was aggression between **A** and **B**.

- On 29th June 2016, **A** appeared at the police station, intoxicated and refusing to return to her home, claiming that **B** was life threatening her if she filled a complaint.

- **A** claimed to have no support and family network and, and no economic resources.

That same day, **A** was taken in by an older sister and the situation was monitored by the local social security services for some time, with the information that **A** was reported to be well, with no alcohol use, and that she was willing to stay with her sister. But about two months later **A** reconciled with **B** and returned to their shared home.

4.2.2. From the health area

The information provided by the local network of Health Centres outlines the following references concerning **A**:

Date	Information potentially relevant for the review
20th March 2009	Has had depressive crisis. History of alcoholism.
29th September 2010	Eye Contusion/Haemorrhage, no mention of cause.
8th February 2013	Says she gave up alcohol last week, but if she sees wine, she can't help herself.
10th July 2013	Reference to jaw trauma/contusion a month earlier, with the presumed diagnosis of "subluxation of the jaw".
3rd June 2014	Relational problem with relatives + Problem due to partner's illness (...). Refers drinking 5 litres of wine a day. Patient with relapse of alcoholism. Victim of aggression by husband (...). Referral to another health professional. (Note: which one is not indicated).
1st July 2014	Bruising on face and nose; wounded in a fall - according to patient.
22nd December 2014	Fall from stairs (10 days prior) with fracture of L1 and nose bones.
22nd April 2015	Appeals for claudication and pain in left lower limb with functional limitation. (...) Swelling of the knee. Scattered ecchymoses over the thigh. Chronic alcohol abuse (will be admitted to a clinic for rehabilitation).
4th May 2015	Cut-incised wound of about 5 cm in occipital region - accidental fall.
24th November 2015	Fracture of radius and cubitus + Disability associated with chronic alcohol abuse.
5th April 2017	Burn/Scald with boiling water - right thigh.
29th May 2017	Patient who came to the USF today brought by a person who saw her in pain and noticed that she had a wound on her arm. Claims to have rubbed her arm into a hot iron.

4.2. Information provided by witnesses

On 3rd May 2019 EARHVD heard the following witnesses:

A´s sister, who briefly reported the following:

- Throughout the marriage there was aggressive behaviour from **B** towards **A**, which worsened over time.
- The violent behaviour intensified after **A** began to use alcoholic drinks. **B** began to threaten and beat **A**, to the extent that she was covered in purple bruising.
- **B** would take away the key to the house where **A** also lived, the mobile phone cards and would not even give her money for the bus so that she could go for medical examinations.

- **B** had already tried to drown **A** in a tank. This fact was widely known in the community, including their daughter.

- The aggressive behaviours were often displayed in the presence of their daughter, having come to the knowledge of the institution where she lived. From that moment onwards the institution stopped allowing visits to her parents.

- The declarant was the only person that **A** could count on. Over a period of time, **A** improved and was stronger. When the declarant move abroad **A** felt overwhelmed by problems.

- On one of the occasions when **A** filled a complaint with the GNR, and when the declarant accompanied her as a witness, she ended up saying that **B** did not hit her.

- The GNR informed her that if **A** denied the facts in court, the declarant statement would be questioned and it would set **B**'s word against hers, so that she could also give up her statement, which she did.

- Shortly before she died, **A** went to the house of the declarant with a broken arm, and the declarant called the GNR, who replied that it was none of their business and that they should call the ambulance.

- **A**'s sister-in-law (**B**'s sister) was aware of all of these episodes, and once poured a bottle of wine down **A**'s head.

- **A** was made to lock the door whenever she left the house and give the key to her sister-in-law. Whenever **A** arrived, the sister-in-law phoned **B** to ask whether to give **A** the key.

- The neighbours never did anything because they were afraid that **B** would harm them, as he threatened everyone.

B's sister, who briefly reported the following:

- During the 15 years she lived near **A** and **B**, they never got along, were obsessed with each other, never having raised the question of separation or divorce, being convinced that the aggressions would only end when one of them died.

- There was mutual aggression, with **A** being more verbally aggressive with **B** and

the latter more physically aggressive with **A**. The arguments resulted in loud noise, sometimes unbearable, and then in these moments she would intervene to keep them apart.

- For a period of time **A** controlled her alcohol abuse and in 2015 was admitted in an institution to undergo rehabilitation treatment for 15 days, following which she did not drink alcohol for a year and a half.

- **B** kept hitting **A** even when she was not drinking, and this was possibly the reason why **A** kept drinking.

- At one point, the health centre contacted her to ask her if she could help **A**, and she accompanied **A** to hospital a few times, namely when **A** fell down the stairs, and a second time when she broke her clavicle, both caused by a fall.

- She thought of filing a complaint with the police several times, but **B** told her not to do so, because he wouldn't harm **A** anymore. She always believed that **B** would change, but the aggressions continued.

- She was never called to testify in the processes in which **B** was the aggressor. She doesn't know if GNR did anything to prevent the situation and she was never approached to ask for information about anything.

- The correspondence was always delivered to her house and then given to **B**.

- The other neighbours paid no attention to the couple's arguments.

4.4. Clarifications from the Republican National Guard

On 18th April 2019, clarifications were sought from GNR, whose response, dated from 27th April 2019. Clarification transcribed herewith:

1. Generically this situation concerns a dysfunctional couple, with strong dependence on alcohol (both of them), in which the husband worked during the week and the wife stayed at home dedicated to housework.

2. The couple's problems were known to the neighbours, and the victim's sister formally filled a complaint to the territorially competent GNR.

3. The situation experienced by this couple was communicated to Social Security, which never managed to rehabilitate them.

4. [A] constantly showed signs of drunkenness and avoided contact with GNR patrols, hiding at home. She always denied her husband's aggressions when questioned about it.

1. **Why was the risk assessment form not applied [in the second report]?**

Answer: [The second report] was based on a complaint submitted by the sister of the victim (...). In this context, the GNR from (...) went to the residence of the presumed victim (...) in order to speak with her, who stated that she was not a victim of domestic violence and denied the facts contained in the complaint.

2. **At the date of the facts did the professionals who intervened in this [case] had specific training on violence against women and domestic violence? If yes, please specify what training they have received.**

   Answer: In the light of the findings, it was concluded that the military personnel did not have specific training in this area of intervention.

3. **In the event that the risk assessment using the RVD-1L form results in a high-risk level grade, it is recommended that the re-evaluation through a RVD-2L form will take place in 3 to 7 days. Why [in the 3rd participation] did the reassessment took place 51 days after the first assessment?**

   Answer: This situation was essentially due to the victim's behaviour because:

   a. When in a sober state (rare exceptions) she would avoid contact with the GNR;

   b. When under the effect of high levels of alcohol (most of the days), she did not respond to contact attempts, as she usually found herself in bed.

   At the time of the police report (...) she was clearly showing signs of intoxication. It was only with "great difficulty" that the military who took charge of the incident managed to get her to report the facts that support it.

4. **The professionals who carried out this risk assessment and reassessment had attended any training on violence against women and domestic violence? If yes,**

please provide details of the training they have received.

Answer: Yes. The RVD reassessment was carried out by the GNR (...), who had attended the NMUME course, in May 2006.

Domestic Homicide Review

05.

Timeline of the case - graphic representation

CHAPTER

05.

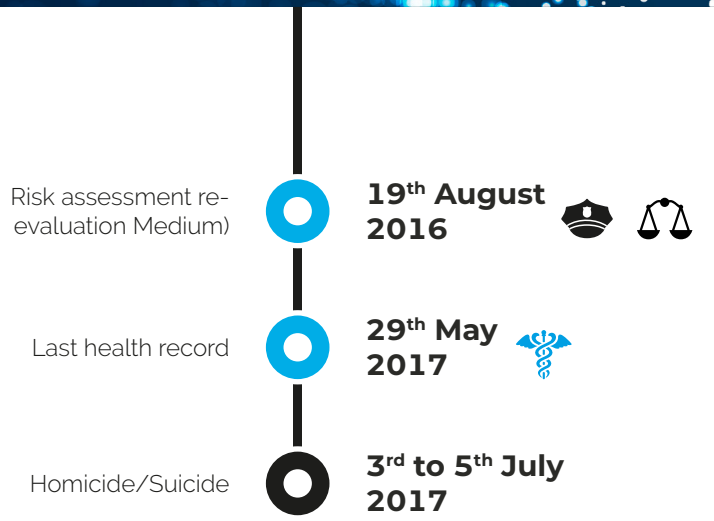
Timeline of the case - graphic representation

Based on the gathered information, a timeline of the case was drawn up, which includes the most relevant events for its analysis.

Timeline – from 20th March 2009 to 3rd July 2017

Follow-up by local network of Health Centre: Depressive Crisis; Alcoholism, Injury to various parts of the body, mentions aggression by B on 3rd June 2016

First medical record	**20th March 2009**
1st enquiry on Domestic Violence (dismissed on 2nd December 2014)	**13th June 2014**
Supporting Centre and PRI Programme	**June 2014 to December 2014 RNAVVD**
2nd Enquiry on Domestic Violence (dismissed on 22nd April 2016)	**21st November 2015**
3rd Enquiry on Domestic Violence – High-risk level (dismissed on 5th September 2016)	**28th June 2016**
ISS and LNES – sheltered by her sister (2 months)	**29th June 2016**



Legend

- Beginning of relationship
- Background/risk factors
- Opportunities for intervention
- Homicide
- Contacts with Justice
- Contacts with Police Forces
- Contacts with Health

On 29th June 2016: Risk assessment HIGH – Identified 11 risk factors:

- No. 1 - Has the offender ever used physical violence against the victim?
- No. 3 - Has the offender ever attempted to strangle (try to choke), suffocate, or drown the victim or other family member?
- No. 5 - Was medical attention required after any assault and/or did the injuries compromise the victim's normal daily activities or those of other family members?
- No. 7 - Has the offender ever used/ threatened to use any kind of weapon against the victim or other family member, or has easy access to a firearm?
- No. 8 - Do you believe that the offender is capable of killing you, or having you killed (are you convinced that he is really capable)?
- No. 9 - Has the offender ever tried to or threatened to kill the victim or other family member?
- No. 10 - Does the offender stalk the victim, intentionally intimidate her, display

excessive jealousy and tries to control everything the victim does?

- No. 12 - Has the offender ever attempted or threatened to commit suicide?
- No. 14 - Has the offender ever been the subject of previous criminal complaints?
- No. 18 - Has the victim been separated from the offender, attempted to/manifested an intention to do so (in the past/next 6 months)?
- No. 19 - Does the victim or any member of the household have special needs and/or support from others?

On 19th August 2016: Risk assessment re-evaluation MEDIUM. Identified 8 risk factors:

- No. 1 - Has the offender ever used physical violence against the victim?
- No. 3 - Has the offender ever attempted to strangle (try to choke), suffocate, or drown the victim or other family member?
- No. 9 - Has the offender ever tried to or threatened to kill the victim or other family member?
- No. 10 - Does the offender stalk the victim, intentionally intimidate her, display excessive jealousy and tries to control everything the victim does?
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- No. 18 - Has the victim been separated from the offender, attempted to/manifested an intention to do so (in the past/next 6 months)?
- No. 19 - Does the victim or any member of the household have special needs and/or support from others?

Domestic Homicide Review

06.

Review

CHAPTER

06. Review

The present case of homicide in domestic violence has at its origin a criminal proceeding that was declared terminated due to the death of the perpetrator. Consequently, the process was dismissed without further investigation of the circumstances in which it occurred.

However, given the evidence gathered by the members of the EARHVD, from which it can be concluded that domestic violence between **A** and **B** had been happening for several years, it becomes essential to frame and understand the variables that were present in this case, as well as what could have been done differently, aiming at the adequate protection of the victim.

6.1. The inconsistent action of the health services

According to the information provided by the health area, **A** has been visiting the local network of Health Centres for several years and several times, presenting several injuries in various parts of the body. Her clinical file includes an episode occurred on 3rd June 2014 that mentions that she was an aggression victim from **B**.

From the information gathered, it does not appear that **A** was questioned about the origin of her complaints referred to in the other episodes, which date back to at least 20th March 2009 (for depressive crisis), and the last one dated 29th May 2017 (for a wound in the left arm). If this happened, no documentary record was made accordingly.

Between 20th March 2009 and 29th May 2017 (during 8 years), 12 medical appointments occurred (the last was 37 days before **A**'s death), without any attempt being made to determine the origin of the injuries, namely if they were caused by domestic violence or, at least, without such an investigation being documented. There is only record, through the testimony of **B**'s sister, that the local network of Health Centres contacted her to find out if she could help **A**. There are no records of any protective measures to prevent the recurrence of these situations, namely by reporting the situation to the authorities that should had investigated the situation and prevent the violence.

In 2013 the health sector addressed interpersonal violence and developed an integrated intervention model throughout the life cycle, The Health Action on Gender, Violence and the Life Cycle (ASGVCV), operationalised through Adult Violence Prevention Team (EPVA). These Teams have, among others, the following competencies:

- To provide consultancy support to health professionals and teams regarding reporting, follow-up or cases referral.

- Manage clinical situations which, due to their characteristics, may be followed up at primary health care or hospital level, and which, due to their urgency in terms of danger, transcend the intervention capacities of other professionals or teams of the institution.

- Encouraging the establishment of intra-institutional cooperation mechanisms regarding interpersonal violence, both within the scope of the professional teams of the ACES, or at the level of the different medical specialities, services and hospitals departments.

(Legal Order of the Assistant Secretary of State of the Minister of Health No. 6378/2013, of 16th May).

In the ACES in question, according to information provided to EARHVD, the respective EPVA had no activity.

We reiterate the recommendations already provided by the EARHVD to the health sector in case reports no. 1/2017-AC, no. 4/2017-VP and no. 1/2018-AC:

a. That health care providers should systematically implement domestic violence screening and that in all screening processes should ask objective questions about the occurrence of violence within the family, recording them - in accordance with the technical reference tool "Interpersonal Violence - Approach, Diagnosis and Intervention in Health Services" of the Directorate-General for Health.

b. That all health service professionals document the statements of patients regarding violence to which they may be subjected and the occurrences that come across in the exercise of their functions.

c. That, whenever there is a justified suspicion or confirmation of domestic violence the health professionals must provide information on available supporting re-

sources and take the necessary safety measures, as well as reporting the situation to the judiciary entities, grounding their intervention on the mentioned technical reference tool.

6.2. The lack of continuous monitoring by the RNAVVD

In 2014, according to information provided by CIG, **A** was accompanied by a RNAVVD support centre as a victim of severe physical and psychological abuse from **B**. She was then referred to a support centre for addiction behaviours, due to alcohol abuse, where she was integrated in the PRI Programme.

The RNAVVD support centre merely referred **A** to the addictions support centre, without having promoted a continuous follow-up in order to provide her with the protection, support and assistance she needed, given the domestic violence context in which she found herself, and which was highly likely to continue, and also bearing in mind her non-cooperation in the investigation and not wanting to leave the house where she lived with **B**.

In 2016, according to the information provided by ISS, the LNES was called by the GNR with a view to **A**'s request for institutional foster care due to a situation of violence. She ended up being sheltered, that same day, at an older sister's home.

Given the information that **A** was well, without no alcohol use and that she was willing to continue living with her sister, the social security monitoring of the situation was not resumed. Social Security didn't provide follow up even after it became known that, after approximately two months, **A** had left her sister's house, reconciled with **B** and returned to the house where she lived with the latter, which was the setting of the domestic violence episode, triggering the sheltering request to the LNES.

In both occasions, 2014 and 2016, the entities of the RNAVVD did not act in a consistent and proactive way.

Their intervention was limited to treating acute situations, without promoting a follow-up to **A**, making the whole context of domestic violence dependent on the resilience of the victim herself, which may have constituted missed opportunities to interrupt the violence cycle.

6.3. The lack of proactive action by GNR and the MP in the investigation and evidence gathering

Three enquiries have been opened for a domestic violence crime committed by **B** against **A**, concerning events that occurred on 13th June 2014, 21st November 2015 and 28th June 2016.

All three were dismissed by the MP, under the terms and for the purposes set out in article 277, no. 2 of the CPP, that is, for failure to obtain sufficient evidence of the confirmation of the crime or the identity of the perpetrators.

In the inquiries into facts that may constitute the commission of a domestic violence crime, the entities responsible for the criminal investigation should develop actions in order to:

a. Investigate and collect evidence on past facts.

b. Understand the relational dynamics between the victim and the perpetrator.

c. Protect the victim and neutralize other violent conducts of the perpetrator.

In terms of article 262 (Purpose and scope of the enquiry) of the CPP, the enquiry "comprises the set of measures aimed at investigating the existence of a crime, determine its agents and their responsibility and discover and gather evidences in order to decide on the indictment".

However, in crimes against people and, specifically, in the domestic violence crime, generally occurring out of sight of witnesses and in a context in which the victim is subject to great embarrassment making it difficult for her to cooperate with the investigation, the use of all legal means of obtaining and gathering evidence becomes even more necessary and challenging.

However, in the inquiries in which facts characterized as domestic violence, of which **A** was a victim, the entities responsible for the criminal investigation did not act proactively.

Both the MP and the GNR did not demonstrate having identified the danger that **B** could pose to **A**, as a result of the long-lasting context of domestic violence to which **A** had been subjected to and of which there was information in the complaints filed against **B**.

The MP dealt with each case individually, without taking into account the information and the background, acting without the investigation and action requirements that knowledge of previous proceedings demanded.

The GNR faced the domestic violence context - which it knew well - as a problem between **A** and **B**, and without a solution.

Both entities refrained, from the criminal point of view, from carrying out an effective investigation and evidence collecting, carrying out actions that were limited to following a formal action, holding the victim´s hesitations, setbacks and non-cooperation responsible for closing the inquiries, and not taking the initiative to identify other means of evidence.

This action was, therefore, clearly insufficient to put an end to the violence cycle to which **A** was subjected to, a situation which continued until her death, occurring about a year after the third report.

This finding corroborates one of the gaps in the proceedings of domestic violence complaints that has already been identified by the Multidisciplinary Technical Commission for the prevention and combat of domestic violence (CTM), established by the Resolution of the Council of Ministers no. 52/2019, of 6th March 2019:

- Non-existence of a uniform binding protocol for police action, that ensures proactivity in the collection of evidence, whether in or out flagrante misdemeanour situations, coherent with the dynamics and public nature of the domestic violence crime.

The CTM Report (Chapter II) presented a proposal of "Procedure to be adopted by the OPC within 72 hours of a report of a crime of maltreatment committed in a domestic violence context", which aims to respond to the requirements of immediate action provided in article 29-A of the LVD – those about conflict characterization, victim protection, revictimization risk assessment, evidence gathering and restraining the perpetrator.

This Recommendation was assumed by the Resolution of the Council of Ministers no. 139/2019, of 18th July 2019, no. 1, paragraph a), item i):

> "... *1 - Identify as priority actions, to be implemented on the basis of the proposals of the CTM established by the Resolution of the Council of Ministers no. 52/2019, of 6th March: (...)*

c) The improvement of the mechanisms to be adopted by GNR, PSP and PJ in the 72 hours following the complaint of maltreatment committed in a domestic violence context, to be promoted by the governmental areas of internal affairs and justice, together with that of citizenship and equality, in articulation with the PGR, namely through:

i) The elaboration of a manual for functional action, by a team that integrates the training and operational structures of the GNR, PSP and PJ, CEJ and PGR, which includes, namely, the procedures that must be developed with a view to the victim´s protection and support, the preservation and urgent gathering of evidence, the restraint and definition of the procedural situation of the perpetrator and the triggering and articulation with the procedures which are simultaneously taking place in the area of family and minors ...".

It is important that this relevant instrument for a better performance of the OPC becomes a reality in the short term.

6.4. Insufficiency of the risk assessment

On 29th June 2016, GNR implemented a risk assessment using the RVD-1L form, whose only information source was victim **A**, and 11 risk factors were identified, resulting in a high-risk classification.

On 19th August 2016, was implemented another risk reassessment using the RVD-2L form, whose only source of information was again the victim **A**, and 8 risk factors were identified, resulting in a medium risk classification.

However, contrary to what is recommended for high-risk cases, which is a re-evaluation within 3 to 7 days, and despite the clarifications provided by the GNR regarding the inability of meeting that deadline, the fact is that, in the present case, the risk reassessment re-evaluation was only developed 51 days after the first assessment.

In the reassessment made through the RVD-2L form, 3 risk factors included in the initial assessment were not identified:

- No. 5 - Was medical attention required after any assault and/or did the injuries compromise the victim's normal daily activities or those of other family members?

- No. 7 - Has the offender ever used/ threatened to use any kind of weapon against the victim or other family member, or has easy access to a firearm?

- No. 8 - Do you believe that the offender is capable of killing you, or having you killed (are you convinced that he is really capable)?

However, no reasons were given as to why these risk factors were no longer reported, whereas with the exception of no. 8, they all are of a static nature. That is to say, once registered in the assessment phase, they persist in the reassessment phase, which in the present case was not duly considered, which determined, to date, the reduction of the classification from high to medium and the weakening of the protective measures indicated.

The risk assessment and reassessment were carried out by someone without specific training. We reaffirm the recommendations that EARHVD has already addressed to the area of police forces in dossiers no. 1/2017-AC (Nos. 1 and 2) and 4/2017-VP (no. 3):

1. That the victim risk assessment (RVD-1L and RVD-2L) must be implemented by specialised professionals with experience in the field of domestic violence. Should this not be feasible in the specific case, that it be supervised by a specialised professional, within a period not exceeding 48 hours.

2. That the steps taken to implement the protection measures and safety plan defined for the victim, as well as the incidents of their implementation, should be recorded in a specific document, which will be attached to the criminal proceedings, so that their effective execution can be known and monitored.

3. Strengthen training on violence in intimate relationships, violence against women and domestic violence, in order to provide more knowledge and skills to frontline police force professionals that will improve their understanding of the characteristics and dynamics of these behaviours, and increase the quality of their work, namely in assisting the victim and evidence collection, risk assessment and the definition and implementation of the safety plan.

We cannot fail to stress the strong trait that, in the cases in which, in the course of the enquiry, the risk to the health, physical integrity and life of the victim is assessed as high, and the investigation is closed due to insufficient evidence, the case should not be purely and simply dismissed. Even when the victim does not want to continue benefiting from a victim status, the situation should, generally, be communicated by the

Public Prosecutor's Office to RNAVVD services so that their follow-up and continuity of social support can be guaranteed (article 24, no. 2 and 3 of the LVD).

6.5. The legitimization of domestic violence by the community

The information gathered in this review allowed us to get to know relevant aspects of the sociocultural context in which domestic violence seems to be perceived, not rarely as an intimate matter of the couple, silenced and tacitly accepted.

From the data from the surveys and the testimonies given by the sisters of **A** and **B** when heard by the EARHVD, it is clear that the domestic violence perpetrated by **B** against **A** was already known to their neighbours and to some people with whom they had personal proximity.

However, in none of the enquiries was there anyone who contributed with his/her testimony to prove the facts reported.

The family, the community and the institutions were strongly influenced by the alcoholism (from both parties) in the way they looked at the couple's conflicts and the violence exerted by **B** on **A**, justifying her passivity by the existence of that context.

In this case, it is also pertinent to reaffirm the recommendation that the EARHVD addressed to CIG, in case report no. 2/2017-JP, so that:

(...) have a particular concern in promoting the combat against domestic and gender in areas with a smaller number of support centres, develop awareness-raising campaigns at the local level that promote the deconstruction of beliefs, myths and stereotypes about violence against women, based on the development of networking with municipalities and the services providers from the National Support Network for Domestic Violence Victims.

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07.

Conclusions

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Conclusions

1. The information gathered in the present case reveals that **A** had contacts over throughout 8 years (20th March 2009 to 29th May 2017) with entities of 5 State intervention areas and the RNAVVD, which proceeded to data collection, but whose interventions were characterized by being merely reactive, partial and discontinued, and that may have constituted missed opportunities for intervention:

Intervention areas	Data collection (summary)	Date
Health	Depressive crisis + history of alcoholism	20th March 2009
Health	Eye contusion/haemorrhage	29th September 2010
Health	Unable to avoid alcohol use/abuse	8th February 2013
Health	Jaw trauma/contusion	10th July 2013
Health	Victim of aggression by husband VD	3rd June 2014
GNR/MP	GNR/MP 1st report against **B** for VD	19th June 2014
Citizenship and Equality/Support Centre/RNAVVD	Serious physical and psychological abuse Referral to PRI	June-December 2014
Health	Bruising of the face and nose wound due to a fall	1st July 2014
Health	Fall down the stairs with fracture L1 + bones + nose	22nd December 2014
Health	Edema in the knee + ecchymoses in the thigh	22nd April 2015
Health	Cut-incised wound occipital region	4th May 2015
Health	Radius and ulna fracture	24th November 2015
GNR/MP	2nd Complaint against **B** for VD	28th November 2015
GNR/MP	3rd Complaint against **B** for VD	29th June 2016
Social Security/LNES/ RNAVVD	Assault and death threats Request for shelter for **A**	29th June 2016
Health	Boiling water scalding/burning	5th April 2017
Health	Arm wound	29th May 2017

2. From 2009 until **A**'s death, the health area only intervenes towards symptomatic treatment regarding physical and psychological lesions, without attempting to investigate their origin, namely if they were caused by domestic violence, without documenting such a search. Even in the only situation where there are records regarding domestic violence, no measures were taken in order to prevent the re-

currence of further events.

3. The RNAVVD support centre, which in 2014 accompanied **A** for severe physical and psychological abuse from **B**, referred the victim to a specific support service for addictions, due to alcohol abuse, however, it ceased to monitor the domestic violence suffered by **A**, which would highly likely continue, bearing in mind the investigation and her unwillingness to leave the house where she lived with **B**.

4. Social security, despite being aware of the gravity of the situation, determined, in 2016, the institutionalisation in a domestic violence shelter. Nevertheless, the victim stayed at a sister's home and was considered stable and social security did nothing more to enquiry about the (lack of) continuity of the aggressions and the need for protection, support and assistance to **A**, who after two months returned to the house where she lived with **B**.

5. Both the Public Prosecutor's Office and the GNR had clearly insufficient action to put an end to the cycle of violence to which **A** was subjected. From a criminal point of view, they both have quit from implementing an effective investigation and gather evidence, by that were limited to following a formal procedure, blaming the hesitations, the retreats and the and non-cooperation of the victim for the closure of the enquiries, and did not take the initiative to identify other means of evidence.

6. In the enquiry that was dismissed due to insufficient evidence, the risk to health, physical integrity and life of the victim was assessed as high - despite the fact that she did not request to continue to benefit from the status of victim - the Public Prosecutor´s Office did not consider communicating the situation to RNAVVD services so that the victim could benefit from social support, under the terms of article 24, no. 3 of the LVD.

7. The intervention system failed as a whole, unable to articulate and pass on the information between the various sectors, to understand and interpret the specificities, the fears, the insecurity, the hesitations and the unspoken hints by the victim, to read the signs in the framework of the victim's great fragility and alcoholic dependence. The local community also seems to have given up on protecting her.

8. No intervention on that family context or on **B**, nor any reference to its importance and necessity, in order to break the cycle of violence.

Domestic Homicide Review

08.

Recommendations

CHAPTER

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Recommendations

In order to fulfil the fourth objective of this report, the EARHVD makes the following recommendations:

- **The EARHVD recommends the support centres form RNAVVD and the ISS, I.P.** to promote the continued monitoring of victims who are identified in a domestic violence context, regardless of whether they have filed a criminal complaint and/or live with the perpetrator, by checking the continuity (or lack of) of the aggression and the need for protection, support and assistance.

- **The EARHVD recommends the Government** to assign urgency to the elaboration of the manual of functional intervention regarding the action of the OPC in the 72 hours following the complaint for maltreatment committed in a domestic violence context, provided for in item i) of paragraph c) of no. 1 of the Resolution of the Council of Ministers no. 139/2019, of 18th July 2019, with a view to better protecting and supporting the victim and the preservation and urgent acquisition of evidence.

Lisbon, 6th December 2019

Representative of the Public Administration body responsible for the area of citizenship and gender equality
Dr. José Manuel Palaio (Permanent Member)

Representative of the Ministry of Justice
Dr.ª Maria Cristina Mendonça (Permanent Member)

Representative of the Ministry of Health
Dr. Vasco Prazeres (Permanent Member)

Representative of the Ministry of Labour, Solidarity and Social Security
Dr.ª Aida Marques (Permanent Member)

Representative of the General Secretariat of the Ministry of Internal Affairs
Dr. António Castanho ((Rapporteur, Permanent Member)

Representative of the territorially competent Police Force (GNR)
1st Sergeant António Paulo Vieira Pinto (Non-permanent Member)

Approval of the Dossier Report No. 2/2018-JP

(Article 6, d), e) and f) of Ministerial Order no. 280/2016, of 26th October)

1. The review of homicides in a domestic violence context aims to contribute to improving the performance of the entities/services involved in the different aspects and levels of intervention in the domestic violence phenomenon, particularly for the implementation of new preventive methodologies.

2. In this specific case, the questioning and analysis focused on the performance of the health, social and support services for domestic violence victims, as well as the investigation and prosecution. The report presents and analyses the actions developed by each entity that had contact with this family context.

3. The review procedure defined in the EARHVD rules of procedure was respected.

4. The conclusions are based on the facts. The report is objective, reasoned and clearly written.

5. The recommendations presented are relevant and timely, in the light of the established facts, of the shortcomings identified and in the application of existing instruments already in place, as well as the need to strengthen the involvement of citizens in preventing and combating domestic violence.

For all the above reasons, I approve the Report.

The Report should be sent to all entities permanently represented in the EARHVD, as well as to the GNR General Commander.

The Report should also be sent to:

- *Parliament Subcommittee for Equality and Non-Discrimination*

- *Portuguese Judicial High Council*
- *Ombudsman's Office*
- *Commission for Citizenship and Gender Equality*
- *National Directorate of the Public Security Police*
- *National Directorate of the Judicial Police*
- *Social Security Institute, Public Institution*
- *Social Security Institutes of the Azores and Madeira*
- *National Institute of Legal Medicine and Forensic Sciences*
- *Directorate-General for Health*
- *Deputy Secretary of Health*
- *Inspectorate-General for Internal Affairs*
- *Inspectorate-General for Health Activities*
- *National Commission for the Promotion of Rights and Protection of Children and Young People*
- *Directorate-General for Reintegration and Prison Services*
- *Centre for Judicial Studies*

In due course, the adapted version of this Report will be uploaded to the EARHVD website.

10th December 2019

Rui do Carmo
Coordinator of EARHVD