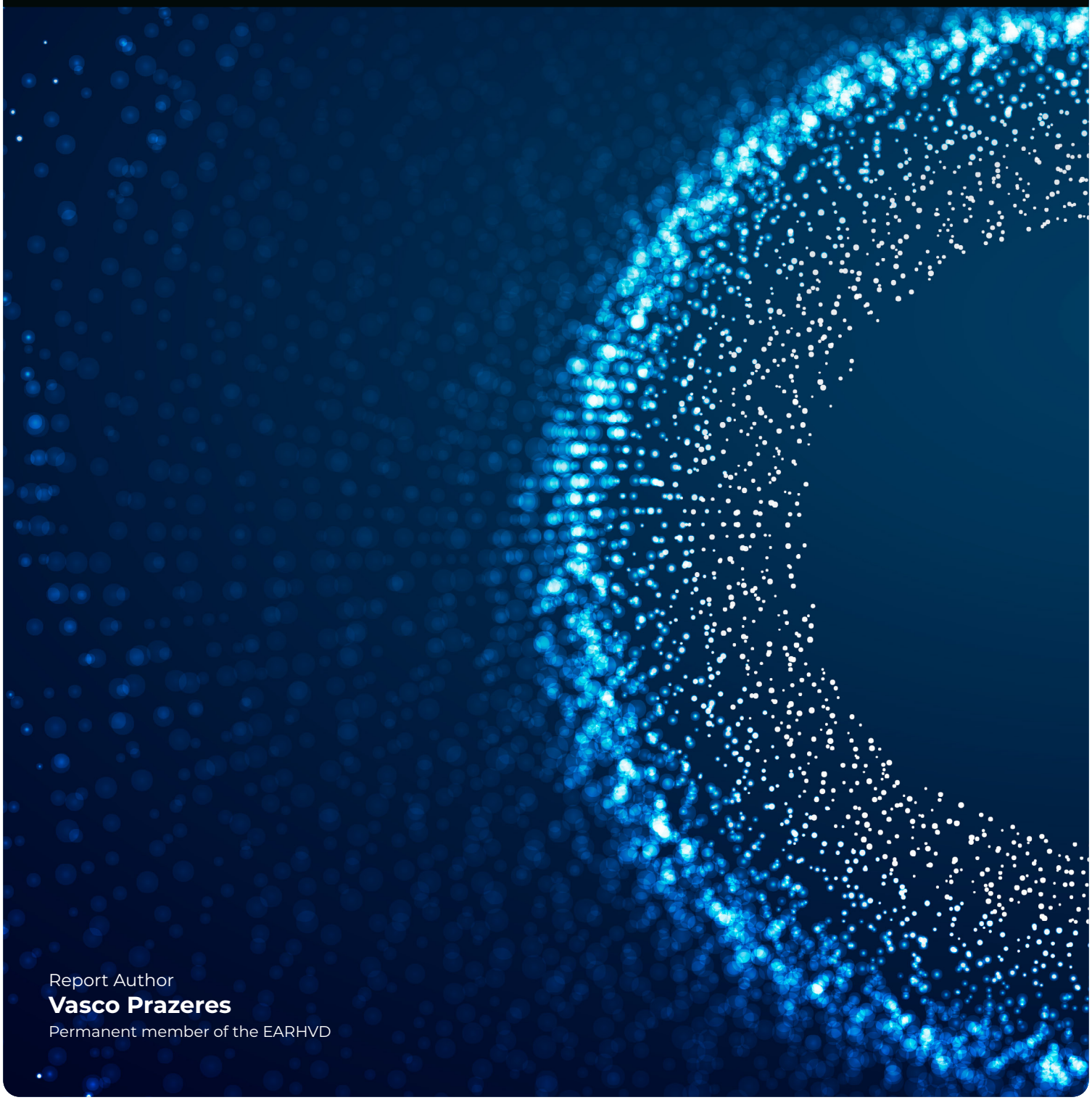
Case: **4/2017-VP**

FINAL REPORT

Domestic Homicide Review

EARHVD
Equipa de Análise Retrospetiva de Homicídio em Violência Doméstica



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Identification of the case

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01. Identification of the case

1.1 The judicial conviction and the review decision

Judicial conviction

This review document concerns the facts that were the subject of the Process (...).

Pursuant to the provisions of the paragraph 4 of article 10, of the Ministerial Order no.280/2016, of the 26th October, which regulates the Domestic Homicide Review procedure, the identification of the parties is presented as follows: **A** - Victim (mother of C); **B** – Perpetrator; **C** – former-partner of B; **D** – friend of C, who would be the person B intended to attack.

In the process identified above, a definitive conviction decision was issued on the 4th April 2017, in which **B** was convicted of a crime of homicide envisaged and sanctioned under the article 131 of the Penal Cope (the victim was **A**), with the sentence of 12 (twelve) years of imprisonment.

The homicide under consideration in this report took place on the 18th February 2016.

Review decision

The Domestic Homicide Review Team – EARHVD understood that, in light of the provisions of article 4, no. 1 of the Law on Domestic Violence (LVD), this situation was within the scope of the cases to be analysed by the Team. This was specifically because of what is stated in article 3, no. 2, item c) of the EARHVD's Internal Regulations: the victim is "a family member or related person of one of the persons referred to in of article 152, no. 1 of the Penal Code."

Furthermore, according to the matter of proven fact, **A**'s homicide occurred in the context of a conflict in an intimate relationship, past and/or present, between **C**, her daughter, and the perpetrator **B**, who had lived as former partners.

In the specific situation under review, as mentioned by the Court of Appeal, **B** "acted in error as to the identity of the person he wanted to targeted", since the addressee of the criminal conduct was **D**, who **B** thought was **C**'s partner, with whom the perpetrator had lived in a non-marital union and sought, then, to renew the intimate relationship.

1.2 Characterisation of the parties involved

Characterisation of A - Victim (*mother of **C***)

- Gender: Female
- Date of birth: 15th February 1929 (87 years old at the time of the facts)
- Marital status: Widow
- Nationality: Portuguese
- Occupation: n.a.
- Employment status: Retired
- Municipality of residence: (...)

Characterisation of B - Perpetrator (*former partner of **C***)

- Gender: Male
- Date of birth: 16th November 1946 (69 years old at the time of the facts)
- Marital status: Widow
- Nationality: Portuguese
- Occupation: n.a.

- Employment status: Retired
- Municipality of residence: (...)

Characterisation of C – Former partner of B (*daughter of **A***)

- Gender: Female
- Date of birth: 25th February 1964 (51 years old at the time of the facts)
- Marital status: Divorced
- Nationality: Portuguese
- Employment status: Domestic work
- Occupation: n.a.
- Municipality of residence: (...)

Characterisation of D – Friend of C (*person that **B** intended to assault*)

- Gender: Male
- Date of birth: 4th August 1956 (59 years old at the time of the facts)
- Marital status: Divorced
- Nationality: Portuguese
- Employment status: Retired
- Occupation: n.a.
- Municipality of residence: (...)

Domestic Homicide Review

02.

Composition of the review team and information sources

CHAPTER

02.

Composition of the review team and information sources

The review procedure started on the 17th November 2017 and ended on the 12th September 2018.

The Domestic Homicide Review Team (EARHVD) was composed by its permanent members, a non-permanent member representing the Republican National Guard (GNR) and an occasional member representing the Local Network of Health Centres (ACES).

Pursuant to paragraphs no. 4 and no. 5 of Law No. 112/2009, of 16th September (which establishes the legal framework applicable to the prevention of domestic violence, the protection and assistance of its victims, hereinafter identified as LVD), the review was based on the following information:

a. Documentation contained in the judiciary process, namely: complaint, interrogation and enquiry records, police forces records, clinical information, forensic-medicine and clinical and psychiatric reports, social service reports, indictment and conviction decision by the First Criminal Court of (...) and by the Court of Appeal of (...).

b. Additional clarifications provided by the GNR-Republican National Guard, at the EARHVD's request;

c. Information from the National Health Service, provided by the ACES-Local Network of Health Centres.

d. Testimony of **C**: hearing held on the 22nd June 2018, at the premises of the City Council of (...).

The collected information from the other Sectors was not considered relevant for this review.

Domestic Homicide Review

03.

Collected Information

CHAPTER

03. Collected Information

3.1. Matter of proven fact in legal proceedings (summary)

- The aggressor **B** and **C** lived together from 2001 until December 2015, when they broke up because the defendant was in a romantic relationship with another person; another interruption in the relationship occurred on an unspecified date between 2009 and 2010.

- On an unspecified date in 2009, **C** got angry with **B** and moved with her mother to her previous residence. However, later in 2010, during a hospitalization when **C** suffered a phlebothrombosis in one leg, **B** went to visit her in the hospital and she ended up moving back with him in his house.

- Besides **B** and **C**, the victim **A** also lived in his house, from 2010 until December 2015.

- After the relationship broke up, **C** and **A** returned to their previous home.

- Unhappy with the end of the relationship, **B** insisted with his former partner to go back to the relationship, which she always denied, despite continuing to meet him and receiving sums of money from him.

- On an unspecified date between December 2015 and February 2016, **B** went to **C**'s residence, and found himself in the presence of **D**, a person who some time earlier had answered the telephone when **B** called **C**; on that occasion D told **B**: "Buddy, leave the lady alone", to which **B** replied: "I already know who the son of a bitch is".

- Also on an unspecified date, **B** punched **D** in the left eye and said "I knew it was you, you son of a bitch", "One day I'll kill you".

- Since then, **B** started to believe that **C** and **D** were in a romantic relationship, and took a wooden bar, about 79cm in length, with a flat overall skin and some protuberances, the thicker part with a diameter of about 3cm and the other end with 2.5cm, which he carried in his car.

- In the early afternoon of 18th February 2016, **B** became aware of **C**'s presence in (...) started to follow her wherever she was going and contacting her on her cell phone, calls that **C** did not answer.

- As the phone calls continued, **C** eventually went to the GNR offices in (...), having been followed by **B**, where they arrived at 5.45 pm.

- **C** just wanted the police forces to dissuade **B** to stalk her, being both advised to solve the problems in a polite and friendly manner, and then both left the station, each driving their own car.

- However, while **C** was returning to her house, she was pursued by **B**, who, while driving on the National Road no.(...), overtook her vehicle, made a sudden movement and collided, hitting the left front of **C**'s vehicle.

- At that point, **B** and **C** stopped their vehicles but did not approach each other.

- Then, **C** went to her house, where her mother was, asking a neighbour to look after her while she went to the local GNR of (...) to report the car accident, as she did.

- Meanwhile, between 6.30 pm and 7.00 pm, **B** also went to **C** and **A**'s residence and, when he got there, he noticed that **C**'s vehicle was not there, so he decided to enter the house, convinced that **D** might be inside.

- Thus, **B** removed the said wooden stick from his vehicle and entered the kitchen of the house, walking through a corridor leading to the room where he believed **C** and **D** were sleeping.

- Then, amidst the darkness, **B** noticed a figure lying face up on the bed, with the sheets and blankets properly aligned up to the neck, approached from the left side and, when he was between the headboard and the middle of the bed, struck the person several hard blows with the stick.

- Then, **B** drove back with the wooden stick that he kept in his car boot, heading to the (...) dam, located near his house, where he stopped his vehicle, removed the stick and threw it into the hill.

- He then went to a cafe called (...), located in (...), where he watched a football game.

- **A** was rescued by her neighbour, whom **C** had asked to look after her mother while she went to the GNR station, alerting other neighbours, who then called the Fire Department to the crime scene; however, **A** eventually died that same day at 7.35 pm

- As a direct and necessary consequence of **B**'s conduct, **A** suffered comminuted fractures (with multi-fragmentation, sinking and infiltration of blood) of the bones of the nose and adjacent cartilage, base of the left orbit, malar, right and left jaws, disarticulation of the left temporomandibular joint. Those injuries were the direct and necessary cause of her death, along with subsequent massive aspiration of blood.

- **B** acted with the intention of taking the life of the person he found on the bed in the bedroom, convinced that it was **D**, whom he knew, in jealousy over the relationship that he thought **D** had with **C**.

- **B** took a stick with him, which he used as an instrument of aggression, knowing that, given the violence and location of the blows he dealt, it would be the certain cause of death, result which he deliberately and wilfully accepted.

Proven fact based on B's social report

- Born in (...), **B**'s socialisation process took place in a modest socioeconomic and cultural context, integrated in the household of origin, with his parents and six siblings.

- **B**'s school pathway progressed to the end of the 4th grade and, at the age of thirteen, he started working in construction with his father, as a bricklayer, a self-employed worker, in a professional area where he was always active, revealing skills and merit to perform this type of work.

- After completing the Mandatory Military Service, he emigrated to (...) where he worked for twelve consecutive years. In 1971, he came to Portugal to marry, having returned to (...) with his wife. From this relationship he has two children.

- In 1984 he returned to Portugal with his family, to live in the house he had built during his years of emigration, in a piece of land he had acquired in the village of his family of origin; the family was reportedly united, and where he was well accepted and integrated, in a respectful and supportive manner.

- Years later, in order to obtain a higher income, he returned to (...), where he worked for some more time.

- When **B** returned to Portugal, he followed through the long illness of his wife, who passed away in 1995, and when the youngest son turned 18 years old, they moved back to (...), where the oldest son and most of his siblings already lived.

- In 2000/2001, he started living in a non-marital union with **C**, **A**'s daughter, a few years younger, professionally inactive. He also shared the household with **C**'s daughter, who was initially institutionalized under a promotion and protection measure. Later, **B** started to pick her up to spend the weekends, and later provided her conditions to study and to have a professional development, ensuring her accommodation in another location, where she went to study and work, in particular by covering the costs of her stay and of obtaining her driving license.

- About three years ago [at the time of the social report], **B** took in **C**'s mother (**A**), who was elderly and in need of better family and housing support. The intra-family relationship was initially cordial and supportive, but, about a year before the facts under review, the relationship began to reveal a dynamic of increasing affective distance; hence in December 2015 **C** left the couple´s home, accompanied by **A**, and they returned to their previous residence, where they faced precarious housing conditions.

- After the break up, **B** mentions that the former partner **C** started another affective relationship, a situation that displeased him and made him jealous.

- During the period when the facts occurred, **B** was living alone in his own house.

- Although the non-marital union established with the victim's daughter (**C**) had ended, **B** reports that he felt disappointed and humiliated, with thoughts that disturbed him, topped with distrust and jealousy, and the idea that she was cheating on him, which in turn generated increasingly aggressive behaviours.

- **B** has retired with monthly income of 780€, enough to ensure his subsistence.

- **B** spent his free time in a quiet way, with a discrete daily life, marked by some family isolation due to the situation of emigration, but with significant social relationships in the community. He usually went out by car with one or another friend to visit cafés and/or restaurants in the neighbouring parishes or in the village centre; he was never reported to be involved in alcohol abuse.

- **B** had little contact with his children and siblings, emigrated relatives, and while he was essentially limited to contacts made via telephone and during the annual holiday periods they spent in Portugal, in their own homes, he kept the connection and affective bonds between them.

- **B** reveals a socially connected daily life, maintained a cordial relationship with the wider community, as well as with the extended family, being described as a hard-working and responsible man, living a quiet lifestyle, and showing a well-adjusted social behaviour; hence the news about his imprisonment were received with surprise.

- Faced with this criminal issue, **B** is capable of judgments of censure, recognizing the criminal offense and is aware of the seriousness of the damage. However, he presents thoughts of legitimization and disclaimers of the act, by in particular circumstances attributing responsibility to what he considers to be "chance", namely when there is an error in the identification of the person to whom the aggression is directed.

- In the present process, **B** presents self-centred thoughts, namely at the level of his deprivation of freedom, and no other impacts resulting from his judiciary situation are perceptible.

3.2. Other relevant information to the review process

3.2.1. Concerning the judiciary intervention

3.2.1.1 On the course of the investigation phase (source: Case)

a. In the **Enquiry Report** carried out by the Judiciary Police on the day of the homicide, on the 18th February 2016, **C** stated that she and her mother "abandoned **B**'s house" because "[she had] information that he was having an extramarital rela-

tionship with another woman (...)". According to the deponent, **B** had tried several times to get back together, "doing everything" to get her to return to him, which she did not accept, because she "did not forgive him for his betrayal".

According to the same document, "during the relationship that lasted about 14 years, (**C**) never treated her or her mother badly, always showing himself very attentive, helpful and fond of both (deponent and mother)".

In the same document is stated that, on the 18th February 2016, **B** "insisted on chasing **C** by car wherever she went, and she threatened **B** that if he did not leave her alone, she would file a complaint with the GNR. He said, "If you go to the GNR I will go too" (sic). Finally, **C** went to the Health Centre to check if her mother's medical report was ready. After leaving the Health Centre, **C** started receiving calls from **B** on her mobile phone, but she did not pay attention to them, because she knew that he wanted to resume the relationship, and she was not willing to.

It is also stated, "While **C** was on her way home from the Health Centre, **B** approached again, chasing her by car; **C** threatened him again that she would complaint to the GNR, which she ended up doing. He followed her, and the two of them ended up stopping in front of the GNR station in (...). Once there (...), **C** informed the GNR officer what was happening. The GNR officer engaged in a conversation with both **B** and **C**, advising them to stay calm and to solve the problems in a polite and friendly way, and that harassing one another would not solve anything. Shortly afterwards the deponent left the GNR station in the direction of her home, **B** took off immediately afterwards..."

b. In the **Enquiry Report** of **B**, the defendant, carried out by the Judiciary Police on the 19th February 2016, is stated: "Regarding the facts under investigation in these proceedings, which occurred on the 18th February 2016, the defendant explains that, during the afternoon, at a time he does not remember, he received a call from the (...) Health Centre with the purpose of finding out whether the defendant knew **C**. The defendant answered that he did not knew her. After making sure that the telephone number did indeed belong to the (...) Health Centre, the defendant went to look for **C** and located her (...) informed her of this fact, and she went to the Health Centre, accompanied by the defendant. Explains that he remained outside waiting for her, and waited there for about 15 minutes (...) He says that **C** passed by and they didn't exchange a word and then went on to the GNR station in (...). The defendant, realizing this fact, decided to follow her and also went to that station."

Note: According to information from the ACES-Local Network of Health Centres (...), there is no clinical record of any face-to-face or telephone contact with B. If this happened, it may have been an informal contact.

c. According to the **Enquiry Report** of the GNR officer who, on the same day, assisted **B** and **C** at the police station, **B** was "very angry, very nervous, speaking in a very loud voice and exhaling an intense smell of alcohol" and "his behaviour indicated that he was drunk".

d. In the **Enquiry Report** of **D**, heard as a witness, conducted by the Judiciary Police on the 19th February 2016, he stated that, as a result of the aggression suffered by **B**, as mentioned in the matter of proven fact, "the deponent approached the GNR station to file a complaint, but was informed that given he had no witnesses, he should not do so until gathering more evidence. As he had no subsequent arguments with that person, he ended up backtracking on the intent to complain."

3.2.1.2 Clarifications provided by the GNR-National Republican Guard

The EARHVD requested clarifications from the GNR on the 12th June 2018, under the terms of the articles no.4-A, number 5 of the Law on Domestic Violence (LVD) and the article no. 10, item 1) of the Ministerial Order no. 280/2016, of 26th October 2016, having received the answers on the 16th July 2018; the clarifications and answers are transcribed below:

1. According to the information obtained in the investigation of the case by EARHVD, **D**, sometime before the homicide occurred, approached the GNR station of (...), to file a complaint for having been assaulted by **B** when he was at the victim´s **A** residence. As he reported to the Judiciary Police, he was "informed that, as he had no witnesses, he should not do so until gathering more evidence".

a. Is it true that the complaint was not accepted or that **D** was advised not to file a complaint because he had no witnesses about the assault? If so, what was the reason for this procedure?

Answer - *Having consulted the file records at the Station, there is no information regarding **D**'s visit to the facilities of the (...) GNR Station.*

b. Is there any written/digital record of this occurrence? If that was not the procedure, what is the reason?

Answer - *No reason can be found, since there is no record of the occurrence. To understand whether there is any lapse, the Commander of the GNR Station of (...) tried to contact the witness, to better clarify the date on which he went to that station to file a complaint of aggression.*

*In the village of (...), the residents say they have not seen the witness **D** since the homicide and the house where he lived is closed. His brother living in (...) had landed the house to him, at the time of the facts.*

The witness is reported to have a sister who lives in the village (...) and when contacted, she said that her brother no longer lives in (...) but somewhere in (...), providing the address only (...).

Several attempts were made to contact him over the phone, always answered by the automatic voice mail.

*When asked, the professionals of the GNR station in (...) and the officer in the homicide case - Principal Guard no. (...), currently working at the territorial station (...) -, they were unaware that witness **D** had come to the station to file a complaint of aggression.*

2. On the 18th February 2016, **C** went to the local GNR station because **B** was pursuing her and kept calling her on the mobile phone, with the intention that the law enforcement officers would stop him from pursuing her. **B** went to the same place at the same time. According to the GNR officer's testimony given to the Judiciary Police, **B** was "very excited, very nervous, talking with a very loud voice and exhaling an intense smell of alcohol" and "his behaviour indicated that he was drunk". **C** and **B** had left the GNR station each in their own car, which collided shortly after and led to a subsequent complaint by **C**.

We request the following clarification:

a. What actually happened when **B** and **C** went to the GNR Station?

Answer - The public attendance at the Territorial Station of (...) on the 18th February 2016, between 4.00 p.m. and 00.00 a.m. was covered by the GNR officer (...), and he reported that **C** and **B** went to the police station.

According to the GNR officer on duty, **C** said that a man had been harassing

her, and when asked if she knew the person in question, she replied that it was this person (nickname).

When questioned by the GNR officer on duty, **C** said that during the afternoon, she had gone to a hairdresser and, when she left, near the Health Centre, there was this man (nickname) inside the car. For that reason, she thought he was chasing her.

Asked if she intended to file a complaint, she replied that she only wanted the man to stop bothering her.

After about 15 minutes, a man arrived at the facility and **C**, addressing the reception desk at the police station, said: "Officer, this is the man who is chasing me! He's been waiting for me outside the Health Centre all afternoon".

Faced with these accusations, the man who was later identified as **B,** contradicted **C**, confirming that he had indeed parked his car that afternoon near the Health Centre because he had gone there to pick up a prescription, which he could easily prove.

b. What are the reasons why it was understood that the facts reported by **C** could not be considered domestic violence and, therefore, no official report was drawn up? In any case, why was no written/digital record of this occurrence made?

Answer - The reason why it was understood that the facts reported by **C** could not be part of a situation of domestic violence is the fact that at no point did **C** manifest her relationship with **B**.

c. Having noticed that **B** had consumed alcoholic beverages, did the GNR officer find out, when B left the Station, what means of transportation he was using? If yes, why didn't he act so that a breathalyser control could be carried out?

Answer - On the date the facts have occurred, the GNR facilities were provisional, functioning in a factory, and the facilities were undergoing construction works, which did not allow the GNR officers at the reception desk to confirm the means of transport of those involved. Also, there was the possibility that the vehicles may have remained in the parking of the (...), as well as the fact that the GNR officer was alone in the outpost facilities and it was not possible to watch over the whole route between the Station and the parking.

3. Was the GNR officer who attended to **B** on the 18th February 2016 the same who had attended **D**?

   Answer - The GNR officer who attended **B** and **C** has no knowledge of **D**'s alleged trip to report an assault, nor does any testimonial or documental evidence show that this visit to the Station actually took place.

3.2.2. Audition of C

The hearing of **C** was held on 22nd June 2018, with the support of the (...) Service of the Municipality of (...). The written record of the hearing is included in the file.

The questions asked had been previously agreed by the EARHVD Team and focused mainly on her relationship with **B**, namely on possible previous episodes of physical, verbal or psychological aggression, on her connection to the local health services and on her contacts with the GNR Station of (...).

In addition to the statements that reflected some of the information in the enquiry reports and the matter of proven fact, **C** made some statements that are worth mentioning.

Regarding her relationship with **B**, **C** stated that they had some disagreements and that **B** would frequently return home drunk and "in a rage" and that, at such times, "he would talk and I would have to shut up, otherwise I would be subject to him abusing me!". After some hesitation, she admitted, "there was a day when I was slapped."

Asked whether if, until the time of the separation in December 2015, she had been sleeping with **B**, **C** replied that, since her mother had moved in with them, mother and daughter had always slept in the same bed, adding that "my mother wouldn't sleep without me being next to her".

About **B**'s contact with **A**, it emerged from **C**'s statements that it was not an affectionate relationship, somehow poor, however devoid of conflict - "He never disrespected her". However, **C** mentioned that in addition to **B** "seeing someone else," it was the fact that her mother wanted to return "to [her] little house" that also dictated the couple's separation.

C admitted she was going to the Health Centre quite often because she "had many health problems aggravated by being very anxious" after "learning" that **B** was seeing

a "lady." However, she stated that she had not told anyone at the Health Centre why she "was feeling like that."

On the 18th February 2016, at the GNR Station and with **B** already by her side, the GNR officer on duty asked "so what's going on?", and she answered: "this man is *following* me around and I don't want him to. I don't want this man following me!" **B** then claimed that "[it was] just to give her the message from the Health Centre", to which C replied, "What you had to give me, you already gave me in the village!" Still according to **C**, the GNR officer then said "So, if you've already given the message, Mr. (**B**'s first name), go away" and added "take it easy!" to which he replied "I'm always taking it easy!"

When questioned about whether or not she had told the GNR officer that she had had a dating or marital relationship with **B**, **C** stated that she did not remember what she told, but added that "everyone knew that we had a relationship... it lasted for so many years... I think they knew... I was with him for so many years..."

Regarding the visit to the GNR station, in addition to the statements that correspond to the record and the factual matter proven in Court, **C** ultimately concluded, "they did nothing and sent us away."

With regard to the alleged fact that **D** had gone to the GNR Station to file a complaint about the aggression by **B** he had been a victim of **C** claimed to have no knowledge that this had happened; she only stated that she knew there had been "a guerrilla war between them".

3.2.3. Concerning the Health Sector

(Source: ACES)

Within the present case review and based on information gathered from the Clinical Directorate of the ACES-Local Network of Health Centres (...), the following additional data has emerged:

a. Regarding the victim (A):

There is no relevant data in the local USF-Family Health Unit, other than those in the judiciary process and "no notes regarding conflicts, family or others can be found in the file".

b. Regarding the aggressor (B):

According to the information provided by the Family Doctor, he shows "no contact made with the local USF-Family Health Unit for the past 2 years (last contact on the 3rd February 2016). No significant clinical records other than old prescription of (...)".

c. Regarding (C):

According to information from the local USF-Family Health Unit, C "is a frequent user of the health services, mainly in the context of unscheduled appointments (open consultations)".

According to the digital records, it was found that:

On the 12th September 2013, there is a record of the occurrence of a phlebothrombosis in the left leg, which warranted hospitalization, as stated in the records;

On the 12th February 2014, an intervention was registered according to the International Classification of Primary Health Care - ICPC-2, with the code Z09, corresponding to "Legal Problem" - it was not possible to identify any record of further details[1];

On the 13th January 2016, **C** had an appointment with her Family Doctor, in whose record is stated, "[she] is very depressed" and was referred to the Psychiatric Emergency Consultation; the content of the clinical information that would have accompanied the referral is unknown;

However, there is a record of "previous appointments, with various reasons related to depression with an anxiety trait".

A Psychiatrist saw C on the 21th January 2016, in the Emergency Service of the Hospital of (...), and the observation record contains, among others, the following elements that seem relevant to the present review:

1 In this regard, the transcription of the descriptive note of this code that appears in the ICPC-2 Manual (ICPC-2e-v.7.0 20 February 2018, English version) is as follows: "Z09 - Legal problem: Problems with legal issues essentially require the patient's expression of concern about them, with agreement about the existence of the problem and desire for help. Whatever the objective legal issues, patients can consider these as a problem. Labelling these problems requires acknowledgement of absolute differences in legal issues as well as the individual's perception."

"51-year-old patient, widow, one daughter (29 years old), lives with her elderly mother for whom she is the caregiver. Referred by her Family Doctor for Psychiatry consultation. No history of psychiatric follow-up, medicated with (...). Patient with an apparent neurotic personality structure who reports nonspecific anxious complaints and sleep disturbance. She describes what seems to me to be a possible obsessive symptomatology and a tendency to ruminative thinking. She reports a weight loss of 4kg that she overrates (despite of being overweight). Generally slow, with marked indecisiveness in speech. Doubts about her baseline cognitive performance (?). Anxious mood, aligned and with preserved reactivity, no signs of suicidal ideation. Referred to the External Consultation for re-evaluation and clinical clarification".

C left with changes to her medication.

On the 2nd March 2016 (date after the homicide under review), she was seen in the Psychiatry External Consultation of the same hospital unit, and the following is contained in the observation record:

"51-year-old patient, widow, one daughter (29 years old), lived with her elderly mother whom she cared for, who passed away two weeks ago. Completed the 5th year of schooling with some failing grades. Seen in the Psychiatric Emergency Service in 16th January, following referral by the psychiatric nurse. No history of psychiatric follow-up, was previously medicated with (...). Patient with an apparent neurotic personality structure who reported nonspecific anxious complaints and sleep disorders. After changing medication, she was put on (...). Today, in consultation, she reports improvement in sleep pattern and appetite, maintaining somatoform anxious complaints. Much difficulty in elaborating the complaints". She left the consultation maintaining her previous medication, plus (...).

She has been followed up in the Psychiatry consultation.

Domestic Homicide Review

04.

Timeline of the Case - graphic representation

CHAPTER

04.

Timeline of the Case - graphic representation

Timeline 2000-2016

- **2000/2001** — Beginning of marital life for **B** and **C**.
- **2009/2010** — Separation followed by reconciliation of **B** and **C**; beginning of cohabitation of **A** with **B** and **C**. **C** starts to share the bedroom with **A**, at **B**'s house
- **2009/2010** — **B** and **C** break up. **A** and **C** move into **A**'s previous residence.
- **Dec 2015 to Feb 2016** — **B** assaults **D**, on the assumption that **D** is in a relationship with **C**
- **Dec 2015 to Feb 2016** — **D** tries to file a complaint with GNR and is discouraged
- **16th Jan 2016** — C is referred to psychiatry by family doctor
- **21st Jan 2016** — **C** is seen in the Psychiatric Clinic (no Domestic Violence records)
- **18th Feb 2016** — **B** chases **C** and **C** seeks help at the GNR Station / Both leave the GNR Station and **B** chases **C** again. **B** heads to **C**'s house and fatally assaults **A**.

Legend

- Beginning of the relationship
- Significant moments/risk factors
- Opportunities for intervention
- Contacts with Police Forces
- Contacts with Health

Domestic Homicide Review

05.

Review

CHAPTER

05. Review

5.1. Scope of the review

This review report aims to achieve a more complete perspective of the circumstances surrounding the matter of proven fact in the present legal case, after the final judicial decision. The intent is to formulate conclusions and recommendations based on the knowledge of the paths taken by the parties and the actions of the entities that interacted with them, until the date when the facts occurred that determined the criminal proceeding.

This document also mentions some information found during the investigation of the dossier report that, although referring to dates after the homicide, were considered relevant for a better understanding of the situation under review.

5.2. Characterization of the relationship between the parties

The non-marital union between **B** and **C** occurred in the period from 2001 to December 2015, with an interruption between undetermined dates between 2009 and 2010. The victim **A** lived with them from 2010 to 2015.

During the enquiry carried out by the Judiciary Police, **C** stated that **B** "had never treated her or her mother badly, and had always been very attentive, helpful and a friend to both of them". The Family Health Unit with which the victim **A** was registered, also expressly stated that there was "no note regarding family or other conflicts". However, during the hearing, **C** hesitantly and timidly told the EARHVD that the intimate relationship with **B** was characterized by psychological abuse and even physical violence. She claimed that, frequently, **B** would return home drunk and "in a rage" and that, at such times, "he would talk and [she] had to [keep] quiet, otherwise she would be subjected" to being attacked, which, according to her, had happened.

On the other hand, during the review it became clear that ever since **A** had moved

into the same house, the couple **B** and **C** did not sleep in the same bed, and **C** started sleeping with her mother. According to **C**, she would have told **B** "if you don't accept my mother, then you will be alone".

After the brake up, potentially motivated by the fact that **B** had another relationship, the latter began to exert constant pressure on **C** in order for her to resume their relationship and cohabitation. That behaviour included repeated attempts of telephone contact, monitoring of movements and pursuits, such as the one that occurred on the day of the homicide and that eventually led to the visit to the GNR Station.

It was in such context that **B**, having met **D** at **A** and **C**'s residence, became convinced that she had started a new intimate relationship with **D**, and got into a physical confrontation with him, verbally threatening to kill him ("One day I'll kill you!"). According to the conviction decision, **B** was convinced it was **D** who was in lying on the bed, where he ended up killing **A**.

5.3. The intervention of the Health Services and the Security Forces

During the course of this review, the information collected allowed us to verify that at least in the three years prior to **A**'s death, the intervention of the various entities in the life journeys of the main parties in this process was scarce. However, it was with the health services that a more frequent interaction existed, specifically in the case of **C**.

It was proven in Court that **B** acted convinced that the person lying on the bed "would be **D**", and that he was acting "out of jealousy in view of the relationship he thought **D** had with **C**". Therefore, the review will not focus on the relationship between **B** and **A**, but rather on the relationship between **B** and **C** and the episode(s) that occurred previously between **B** and **D**.

5.3.1. Health level intervention

The only relevant interaction with the health services was held with **C**.

Frequent contacts occurred with the health services over the years, particularly in primary health care/Family Health Units (USFs); this frequency increased substantially after **A**'s homicide, usually in unscheduled appointments ("open consultations").

In the consultation records some biomedical health issues are mentioned, and it is stated that **C** "has a history of depressive pathology although the condition has been under control and stable". However, no explicit reference is made to situations of interpersonal conflict, namely in the context of an intimate relationship. There is only a record of one intervention corresponding to a "Legal Problem" (ICPC-2), on the 12th February 2014, and it was not possible to identify further details [see point 3.2.3. c)].

According to the statements given at the hearing, **C** admitted that she often went to the "health centre" because she "had many health problems aggravated by being very anxious" since she "learned that **B** "was dating a lady". However, she "never told anyone at the health centre" why she "was feeling like that."

About a month before the homicide, on the 13th January 2016, the Family Doctor referred **C** to an emergency psychiatric consultation at the hospital, which took place on the 21st January. The reason for C to be referred to such urgent care could not be determined. Follow-up in an External Psychiatry Consultation began on the 2nd March 2016. In this first appointment, it was recorded that **C** "... lived with her elderly mother whom she cared for, who passed away two weeks ago...". There is no mention to homicide or the traumatic circumstances under which the death occurred.

It should be noted that no reference was made in the health information gathered by either the Family Medicine or the Psychiatry, to a possible connection between **C**'s emotional status and the events occurred between December 2015 and February 2016 (described above in section 3.1.), which overlapped the dates of those medical appointments.

From the information gathered, it can be observed that:

a. there is no indication about the probable ethiology of her clinical condition, nor of the context of the patient, and no mention is made of any intervention to assess the risk of psychological and/or physical violence, either by the Family Health Unit or the Psychiatry Service of the hospital;

b. when redirecting **C** from the primary health care services to hospital care, c no exchange of detailed information about her depressive history could be found;

c. there is also no specific reference to the social and family context of **C** in the Hospital Psychiatry Services records, despite this being inevitably associated to her clinical situation.

By means of the contact made by the Regional Partner of the Health Action on Gender, Violence and the Life Cycle (ASGVCV) with the Adult Violence Prevention Team (EPVA) of the ACES-Local Network of Health Centres of (...) it was possible to establish, that they had not received any reports related to this case.

There are no records in the National Health Service computer system of any facts classified as interpersonal violence, namely domestic violence, in the context of the family life either before, or during the weeks mediating the couple's separation and the perpetration of the homicide.

In short, on several occasions during the clinical follow-up, severe psycho-affective distress was detected in **C**, which justified not only the use of pharmacological therapy, but also the provision of specialized psychiatric care. However, it could not be ascertained whether the health professionals were aware of what was happening or, on the contrary, if they were aware however, completely omitted the information from the records and from the exchange of information between professionals and departments.

In addition of being responsible for the strict clinical management of situations of this type, the National Health Service (SNS) also has a mandate to investigate the social and family determinants of such situations and take action in order to resolve them.

5.3.2. Police Forces level intervention

Firstly, it should be highlighted that on same day of the homicide, the 18th February 2016, and before the time it occurred, **C** had two direct and voluntary contacts with the GNR station in her area of residence.

The first contact, asking for help, after **B** "[started] following her to the various places where (...) she was going and contacting her on her mobile phone, calls that **C** did not answer. As the phone calls persisted, she ended up going to the GNR facilities in (...), being followed by **B**, where they arrived at 5.45pm". Also, according to the matter of proven fact, **C** "only wanted the GNR officers to stop **B** from pursuing her", and "both were advised to solve the problems in a polite and friendly manner, and then both left the station, each driving their own vehicle". **B**, as recognized by the GNR officer who attended them, was "excited, very nervous, talking with a very high tone of voice and exhaling an intense smell of alcohol" and "indicated by his behaviour that he was drunk".

The second contact occurred in the same afternoon, a short time later, when she went,

again, to the GNR Station to report the traffic accident, in accordance with the facts proven in the conviction decision: "Afterwards, **C** (...) approached the GNR of (...) to report the traffic accident, as happened".

It should also be noted that **D** told the Judiciary Police, following the aggression he suffered by **B**, at the residence of **A** and **C** (as stated in the matter of proven fact), that "he even went to the GNR station to file a complaint, but was advised that, as he had no witnesses, he should not do so without having more elements. As he had no further arguments with that person, he ended up backtracking in his intention to complaint".

From the information gathered, it can be established that:

a. No record was made of the first incident that occurred on 18th February 2016 between **B** and **C**, mentioned above, nor of the **D**'s visit to the security force's station, as confirmed by the GNR;

b. Even considering that the GNR officer who attended **C** may have been unaware of his previous relationship with **B**, at the time of the visit to the GNR station, no action was taken to clarify the reasons why he was "pursuing" her, what kind of relationship they had, or to obtain more information about their dispute. This enquiry would have been of great relevance, since knowing the motivation for **B**'s actions would have necessarily determine a different stance on the part of the GNR officer. It would have been crucial to measure whether the facts reported were likely to constitute a crime of domestic violence [cf. art. 152, 1, b) Penal Code], according to which a criminal procedure is not reliant on a complaint, with the respective obligation to report it [art. 242, 1. a) Penal Code Process] and follow the procedures established in article 29 and 29-A of the Law on Domestic Violence (LVD);

c. Regardless of the criminal classification of the reported facts, **C** did not have the opportunity to be heard or to report what was happening in a private context, which the situation obviously required. Also, taking into account **B**'s exaltation and drunkenness, the GNR officer did not act to safeguard the safety of **C**, who states that "they did nothing and sent us away";

d. The information given to **D** that he should not file a complaint because he had no witnesses was not correct. In addition, no initiative was taken to investigate the context and circumstances in which the threat and aggression had occurred, which called for a special concern for the protection of the complainant.

5.4. Omissions or insufficiency of records

One aspect standing out from the description of the health services and police forces action is the insufficiency of the health records and their omission from the GNR reports, despite the existing signs of recurrent significant episodes, either direct and/or indirect. As a result, there was no known history of this conflict until the death of **A** and no exchange of information between departments and their representatives.

In particular, regarding the analysis of the contacts established between **C** and the health services, on one hand, and, on the other hand, with the security forces, it is possible to uncover missed opportunities to intervene in the conflict that motivated the homicide. Such interventions could have contributed in a decisive way to put an end to **C**'s situation, both before and after the separation from **B**, and could have even prevented **A**'s death.

The non-recording of episodes and facts that may signal, or highlight, the existence of interpersonal violent behaviour in its multiple forms, means that any episode detected at a given moment always seems to be the "first time" or an isolated, fortuitous act, thus masking the severity and extent of the violence exerted. The inexistence or insufficiency of these records translates into the loss of an element of appreciation that, *a posteriori*, may prove crucial to assess the outlines and the intensity of the aggressive behaviour in the scope of the criminal law. Furthermore, it also negatively impacts the assessment of the situation and the type of intervention needed on each of those occasions.

Domestic Homicide Review

06.

Conclusions

CHAPTER

06.

Conclusions

The following conclusions could be drawn from the information gathered and the case review:

1. The homicide of **A** occurred about two months after the separation between **C** (**A**'s daughter) and **B** (the perpetrator), who had lived together for more than thirteen years, with **A** cohabiting with them for the last five years. From the date of the separation, **B** exerted constant pressure on **C** to resume their relationship and cohabitation, behaviour that included repeated phone calls, monitoring of movements, and harassment.

2. The homicide occurred on the 18th February 2016, while the victim was lying in bed in the bedroom where she lived with her daughter. According to the condemning decision, B acted in the belief that D was there instead, a person who had already answered his phone call at C's residence after the separation, having also found him later in the same place and assaulted him, telling him "One day I will kill you", thinking that he had an "intimate relationship" with **C**.

3. **C** maintained regular contact with the National Health Service, over the years. In her records:

   a. no explicit reference is made to situations of interpersonal conflict, namely in the scope of intimate relationships;

   b. no reference is found, either in the scope of Family Medicine or Psychiatry, to a possible relationship between **C**'s emotional situation and the events that occurred between December 2015 and February 2016, a period overlapping the consultations she attended;

   c. no referral was made to the Adult Violence Prevention Team - EPVA of the ACES-Local Network of Health Centres;

   d. a probable etiology for the clinical presentation has not been indicated, no con-

text has been given, and no intervention has been suggested to help assess the risk of domestic violence, psychological and/or physical, either by the Family Health Unit or the Psychiatry Service at the Hospital;

4. Three face-to-face contacts of the intervening parties in this case with the GNR were identified:

a. one, initiated by **D**, with the intention of reporting a complaint of aggression by **B** of which he had been victim;

b. two, on the date of the homicide, initiated by **C**. Firstly, to ask for help because of **B** stalking behaviour that day; secondly, because the car driven by **B** had collided with hers, shortly after leaving the GNR station. No record was made either of **D**'s visit to that station or of **C** first being attended.

5. At the time of C's first approach to the the GNR station, at which B also attended later, exalted and visibly drunk, there was no concern about:

a. clarifying the reasons why **B** had been stalking **C**;

b. understanding what connection or type of relationship they had with each other, or consequently to collect more information about their dispute;

This would have determined a different stance from the GNR officer, considering, in particular, whether the facts reported were likely to constitute a crime of domestic violence [cf. art. 152, 1, b) Penal Code], whose criminal procedure is not reliant on a complaint, with the respective obligation to report it [art. 242, 1. a) Penal Code Process] and follow the procedures established in article 29 and 29-A of the Law on Domestic Violence (LVD);

6. Regardless of how the reported facts qualify:

a. C was not given the opportunity to be heard or to report what was happening in a context of privacy, which the situation obviously required;

b. nor did the GNR officer act in such a way as to ensure **C**'s safety, in light of **B**'s exaltation and drunkenness;

7. The various contacts with the National Health Service and the GNR were missed

opportunities to intervene in the dispute underlying the crime, either because the officials involved did not have adequate training to identify and act upon it, or because they chose to act only upon its manifestations without investigating its root cause.

8. The non-recording of episodes and facts that may signal, or highlight, the existence of interpersonal violence behaviour in its multiple forms, translates into a loss of relevant information about the history, severity and extent of violence, which may negatively influence its assessment, the definition of needs and the type of intervention, also causing the loss of an element of appreciation that may prove crucial for the qualification of aggression in the criminal sphere.

Domestic Homicide Review

07.

Recommendations

CHAPTER

07.

Recommendations

In view of the conclusions drawn from the case report review, the following recommendations are presented:

In the area of Health, the EARHVD:

1. **Reiterates the recommendation**, made in Dossier no. 1/2017-AC, approved on the 31st October 2017, which follows:

   a. Health care providers should systematically investigate the risk of domestic violence; that all screening processes should ask objective questions about the occurrence of violence within the family, of which a record should be made - according to the Technical Standards "Interpersonal Violence - Approach, Diagnosis and Intervention in Health Services" from the Directorate-General for Health.

   b. All health officials document the statements of users about violence to which they may be subject and the occurrences in this area they may come across while performing their duties.

   c. Whenever there is a well-grounded suspicion or confirmation of domestic violence, the health professionals should provide details about the existing resources to support the victim, and should take the necessary safety measures, as well as report the situation to the judiciary entities based specifically on the mentioned technical standards tool.

2. Also **recommends** that all these situations should be referred to the EPVA-Adult Violence Prevention Team of the local health unit, which are well positioned to engage in a privileged dialogue with other entities within the National Network of Support to Victims of Domestic Violence and with the Judiciary Entities.

3. Recommends the strengthening of training for health professionals in the area of violence in intimate relationships, violence against women and domestic violence,

including insights on how to detect it and subsequent intervention.

In the area of Security Forces, the EARHVD:

1. **Recommends** training reinforcement regarding violence in intimate relationships, violence against women and domestic violence, in order to provide a greater number of first line professionals in the police forces with the knowledge to improve their understanding of the characteristics and dynamics of these behaviours. In addition, training will increase the quality of their action, particularly in attending and supporting the Victim, collecting evidences, and also the quality of risk assessment and due definition and implementation of the Victim safety plan.

2. **Recommends** that any incident or intervention related to the possible existence of violence in interpersonal relationships should be recorded, even if it does not give rise to any legal proceedings.

(...), 12th September 2018

Representative of the Ministry of Health
Dr. Vasco Prazeres

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

Representative of the Ministry of Justice
Dr.ª Maria Cristina Mendonça

Representative of the Ministry of Labour, Solidarity and Social Security
Dr.ª Aida Marques

Representative of the General Secretariat of the Ministry of Internal Affairs
Dr. António Castanho

Representative of the territorially competent Security Force (GNR)
Corporal-in-chief Alberto Bastos Mendes (Non-permanent Member)

Representative of the ACES-Local Network of Health Centres
Dr. Raul António Barbosa Varejão Borges (Eventual Member)

Approval of the Dossier Report No. 4/2017-VP

(Article 6, d), e) and f) of the 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 investigation and analysis focused in the police forces and health services action. Those were the entities that, during the period under analysis, had contact with the parties involved and with their social and family context. Appropriate steps were taken in order to obtain the information needed to clarify the procedures carried out.

3. The review procedure defined in the norms that regulate the activity of the EARHVD 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 light of the facts established and the shortcomings evidenced in the approach to the case.

For all the above reasons, I approve the Report.

The Report should be sent to all entities permanently represented in the EARHVD, to the General Command of the GNR and to the Representative of the Executive Director of the ACES-Local Network of Health Centres (...).

The Report should also be sent to the

- *Portuguese Judicial High Council*
- *Ombudsman's Office*

- *Deputy Secretary of Health*
- *CIG*
- *National Directorate of the Public Security Police*
- *National Directorate of the Judiciary Police*
- *National Institute of Social Security, IP*
- *Social Security Institutes of the Azores and Madeira*
- *National Institute of Legal Medicine and Forensic Sciences*
- *Directorate-General for Health*
- *Inspectorate- General for Internal Affairs*
- *Inspectorate-General for Health Activities*
- *Directorate-General for Reintegration and Prison Services*
- *National Commission for the Promotion of Rights and Protection of Children and Young People*
- *Centre for Judiciary Studies*

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

28th September 2018

Rui do Carmo
Coordinator of EARHVD