

Case: **8/2018-AC**



**EARHVD**

Equipa de Análise Retrospectiva de  
Homicídio em Violência Doméstica

# FINAL REPORT

**Domestic Homicide Review**

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Domestic Homicide Review

# 01.

## Case Identification



CHAPTER

# 01.

## Case Identification

The current domestic homicide review document pertains to the facts subject of NUIPC (...), MP from (...) dismissed in 13<sup>th</sup> June 2018, under the terms of the provisions of article 277 of the CPP, due to the death of the defendant, who committed suicide.

The homicide victim was a 50 years old female; the murderer was her husband aged 61 years old.

The homicide and suicide occurred on the 7<sup>th</sup> November 2017.

The main objectives of this report are:

- To systematize the information that was collected, in order to allow a clearer understanding of the reality, of the behaviour pattern and of the determining factors, as well as of the entities'/organisations' responses and support provided to the parties involved;
- To draw lessons from this case, as broadly and thoroughly as possible, to better understand what happened and, more importantly, what needs to be changed to try to avoid similar events in the future.

The EARHVD was composed by its permanent members and one non-permanent member representing the GNR.





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# 02.

**Characterisation of  
the parties involved**



CHAPTER

# 02.

## Characterisation of the parties involved

In accordance with the provisions of the Ministerial Order no. 280/2016, of 26<sup>th</sup> October, article 10, no. 4, diploma that regulates the domestic homicide review, all data allowing the identification of those involved in the judicial process were eliminated. In the review performed which resulted this report, the victim will be identified as **A** and the perpetrator will be identified as **B**.

### Characterisation of A - Victim

- Sex: female
- Date of birth: 50 years old at the time of the occurrence
- Marital status: married
- Nationality: Portuguese
- Home municipality: (...)

### Characterisation of B - Perpetrator

- Sex: male
- Date of birth: 61 years old at the time of the occurrence
- Marital Status: married
- Nationality: Portuguese
- Home municipality: (...)



C - A and B's son (youngest)

D - A and B's son





Domestic Homicide Review

# 03.

**Documentation  
Obtained and  
Reviewed**





## CHAPTER

**03.**

# Documentation Obtained and Reviewed

Under the provisions of paragraphs 4 and 5, both part of Article 4-A of Law no. 112/2009 of 16<sup>th</sup> September (LVD), the review was based on the following information:

- MP's enquiry;
- Testimonies of **C** and **D**, **A** and **B**'s children;
- Clarification from GNR;
- Clinical information.

No information relevant to the review was obtained from any other sector.

All documents were anonymized.



Domestic Homicide Review

# 04.

**Information collected**





CHAPTER

# 04.

## Information collected

### 4.1. Information from the enquiry

#### 4.1.1. MP dismissing Order (summary) and conclusions from the forensic autopsies

On 7<sup>th</sup> November 2017, **B** and **A** were reported missing by one of their children (**C**).

The next day, **C** reported to the GNR that his parents' car had been located on the street (...). The police went to the location and about a hundred meters from where the vehicle was located, closed and without any visible damage, they found **B**'s corpse hanging from a tree with a rope tied around his neck. At 4.30 pm on the same day, the corpse of **A** was found in the cellar of the couple's residence, suspended by the neck on a metal chain attached to the ceiling.

It is clear from the records and, in particular, from the testimonies of both children of the couple, that the marriage was marked by domestic violence episodes motivated by **B**'s jealousy. From the evidence gathered at the couple's home, everything seems to indicate that, on that day, there had been an argument in the living room, where a lock of hair, that is presumed to be **A**'s, was found.

**A**'s body was found in incomplete suspension, hanging by a chain from a hook from the cellar. Taking into account the injuries on her neck, as well as in the interscapular area and on the knees, the drag marks on the clothes and the cellar floor, **B** would have been first choked and then strangled with the chain, then dragged to the cellar and hung on the hook.



After killing **A**, **B** is said to have climbed to the second floor of the residence and changed clothes, left the house in his vehicle and drove to the forest where he ended his life. His body was found with his clothes well-worn and lined up, showing no evidence of violence from a third party.

The forensic autopsy report on **A**'s body concluded that her death was due to mechanical asphyxia by extrinsic constriction of the neck, being cause of a violent death. The ecchymoses of the cervical region adjacent to the groove were the result of trauma of a blunt nature or acting as such, compatible with extrinsic constriction of the neck by hands strangulation. The grooves found on the neck, made by the tie applied to the cervical region (metallic chain with which she was found suspended) were compatible with strangulation and subsequent of the victim in the place where she was found. The conjugation of these elements is consistent with a homicidal forensic aetiology.

In turn, the forensic autopsy report to **B**'s body concluded that his death was due to mechanical asphyxia by extrinsic constriction of the neck - hanging, being the cause of a violent death.

The couple had arguments arising from the jealousy that **B** felt towards **A**, which led **A** to emigrate with her son **D**, despite having resumed her relationship with **A** in the country where she moved to.

When these facts occurred, **A** was on vacation in Portugal and decided to return to the country where she had emigrated at an earlier date than originally planned, because of an argument she had with **B** and the confrontation **B** had with his son **D** on the eve of the death of **A** and **B**.

#### **4.1.2. Statement from a neighbour to the Judiciary Police**

He never saw any arguments between the couple, but **B** repeatedly told anyone who would listen that **A** was cheating on him, that the younger son was not his but son of a pastry chef that she had met in the country where they had moved, among other things that he cannot currently recall. He attributes these suspicions to **B**'s unfounded jealousy.

He also reports that at one point, many years ago, his wife told him that she had seen **B** beating **A** with a whip or a stick on the stairs of the house where they lived.





### 4.1.3. C and D's statement to the Judiciary Police

#### 4.1.3.1. C's Statements

When questioned by the PJ, **C** provided, among others, the following information (summary):

- His father (**B**) created conflictuous situations with a large number of people and, sometimes for nonsensical reasons he ended up distancing himself from friends, neighbours, and relatives.
- At home, he displayed a degree of violence that he did not show in public, particularly toward his wife and their children. When **C** was still a child, this violence ended up taking the form of physical aggression, but more recently it was limited to verbal and psychological violence exerted upon **A**.
- His father controlled all aspects of the mother's life - her routines, social contacts, communications - checking daily to see who she had called and the calls she had made or received.
- Around the summer of 2017, in late July (if he is not mistaken) the mother went to (...), to stay with their son **D**. But **B**, even from a distance, continued to monitor every step and aspect of **A**'s life. Every day, by video call, she would tell him everything she had done, with whom she had spoken, where she had gone, in calls that could last up to 4 hours.
- On 31<sup>st</sup> October of the same year, **A** and **D** came to Portugal on vacation. There were no discussions between **A** and **B**, although he had heard that **B** had found out the code to **A**'s cell phone and had seen her mother hand it to him so that he could "see whatever he wanted". On 5<sup>th</sup> November, after they had all been together, she learned from his mother and brother (**D**), that **A** and **B** ended up arguing (over something his father saw when he went to check mother's FACEBOOK) and that **D** got into a physical confrontation with **B**.



#### 4.1.3.2. D's Statement

When questioned by the PJ, D provided, among others, the following information (summary):

- He is emigrated in 2009, only coming to Portugal on vacation.
- His parents (**A** and **B**) have always had a conflictive relationship marked by frequent arguments, his father being very jealous and possessive.
- To get away from this situation, in July 2017, his mother went to work with him, but kept in touch with his father, talking on her cell phone and through social networks.
- They returned to Portugal on the 31<sup>st</sup> October for vacation. During the first week, there were no problems or discussions, being also present his brother (**C**), who was absent on the 5<sup>th</sup> November. On this day, **B** decided to check **A**'s cell phone, accusing her of "fooling around with a brother-in-law", exchanging insults and threats. **D** also got involved because **B** accused him of "not watching his mother properly while she was in (...)", **D** slapped him and they both fell on the terrace. D apologised to his father and "the situation cleared up between the two of them".

#### 4.2. C and D's hearing by the EARHVD

The EARHVD contacted **A** and **B**'s children in order to obtain more information that would allow a deeper understanding of the domestic violence context, as well as getting to know possible contacts that may have existed with services and the community. From the hearing, we highlight the following aspects that characterize this family experience.

1. **C** and **D** remember that **B**'s violence towards **A** has always existed, with the earliest memories of the time when they were 4/5 years old.
2. **B** has always been jealous, but this characteristic got worse after he stopped working (he worked until he was 50 years old). He would persistently think about old events and sometimes after a few years would confront **A** about it. Most of the time, **A** could only go out with her children. **B** only allowed **A** to have a cell phone in 2016, when son **C** entered higher education.





3. **A** told **C** that his father had assaulted him when she was pregnant with him. From the age of 13 onwards **C** began to object to **B**'s violence, and felt that, as a result, he became the target of his "anger and hatred".
4. As **B** became more violent, **C** had to run away from home with her mother several times. In one of these occasions, they ran away to the GNR station and stayed there for some time without knowing what to do. **B** followed them there and, out of fear, they decided to go to the police station and ask for help. One of the GNR agents stopped **B**, who ended up also entering the station. They were all there for several hours, but the episode was not recorded by the GNR because, once again, they considered the better option to be not filing a complaint against **B**.
5. **C** reports that he felt the situation was getting more and more serious; in fact, on an unspecified date between 2016/2017, **A** left her cell phone recording an argument in which **B** told her "I just want to cut your neck off".
6. Because they felt that **B** was depressed and very unstable, **A** and **C** decided to seek help from the family doctor at the health centre. The family doctor referred **B** for a psychiatric consultation and told **A** that, given her husband's behaviour and as far as she could understand, **A** was in a life-threatening situation. **B** was medicated and initially calmed down, but abandoned some of the medication shortly after.
7. It was because they realised that the situation was escalating that **A** ran away to stay with **D**, who was living abroad. This escape was prepared in secrecy, because they were afraid that the father could unleash some serious violent behaviour.
8. Around September 2017, as **B** seemed to be more in control and more "amenable," **C** began visiting his father at her mother's request, although she had the perception that **B** would be able to kill them all.

### 4.3. Information provided by the Republican National Guard

The GNR was requested a clarification regarding the information described in points 4 through to 4.2. An email was received on 16<sup>th</sup> October 2019, stating that "there was nothing more to add about the case or about the people involved in the situation" and



that “there was no previous complaint” to the homicide followed by suicide that is the subject of this review.

## 4.4. Information from the health sector

### 4.4.1. Information from the Local Network of Health Centres

From the data provided by the ACES, the relevant information to the review concerning **B** is the following:

On 17<sup>th</sup> March 2015:

- Feelings of anxiety/nervousness/tension
- Depressive syndrome medicated with antidepressant and antipsychotic
- Therapeutic counselling/therapeutic listening.

On 4<sup>th</sup> June 2015:

- Diagnosis of depressive disorder

In the observations it is stated that:

- Sleep disorder + Sensation of Anxiety/Nervousness/Tension + Acute Reaction to “Stress” + Sensation of depression + Decreased sexual desire + Decreased sexual satisfaction.
- Psychiatric status: Patient with paranoid personality traits and delusional symptoms of jealousy.

### 4.4.2. Clarifications provided at the request of EARHVD

Considering the information present in the file, the aforementioned elements made available by ACES and the statements provided by **A** and **B**'s sons, further information was requested to clarify the following aspects:



1. Taking into account the data recorded in the individual medical record, namely the information conveyed by a psychiatrist on the personality traits of that person, what type of clinical follow-up was given to **B**?
2. If there was no clinical follow-up on the situation, as a result, for example, of **B**'s compliance to this process, was any alternative follow-up initiative taken, or possible protection of **A** from the possible negative repercussions of this situation?
3. With regard to statements made by one of the couple's sons, according to which **A** was warned by her family doctor that "her life was in danger" – we question:
  - a. Did this happen (date?) as a reaction to any relevant information provided by **A**?
  - b. Was any agreed intervention protocol followed in the health sector, namely that of the Technical Standards "Interpersonal Violence - Approach, Diagnosis and Intervention in Health Services" of the Directorate-General of Health?
  - c. Was this information about the danger to which **A** was subjected shared with any victim protection organization or Police Force?
  - d. Were there medical appointments subsequent to the one in which the "life-threatening situation" was identified, or were there any other type of subsequent contacts to evaluate the situation?

In response, the following clarifications were obtained:

1. The family doctor says she has no recollection of saying that the patient's "life was in danger".
2. **B** was referred for Psychiatric consultation.
3. **A** informed that **B** had attended a psychiatric consultation and had been medicated accordingly.
4. Later **A** informed that **B** did not comply with the therapy, since he considered that the one with some pathology was **A** and not himself; in this context, **A** agreed to go to a consultation with the same psychiatrist.





5. From the date on which the two elements of the couple began to be followed in Psychiatry, the family doctor no longer had contact with the situation.



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# 05.

**Timeline of the case –  
graphic representation**

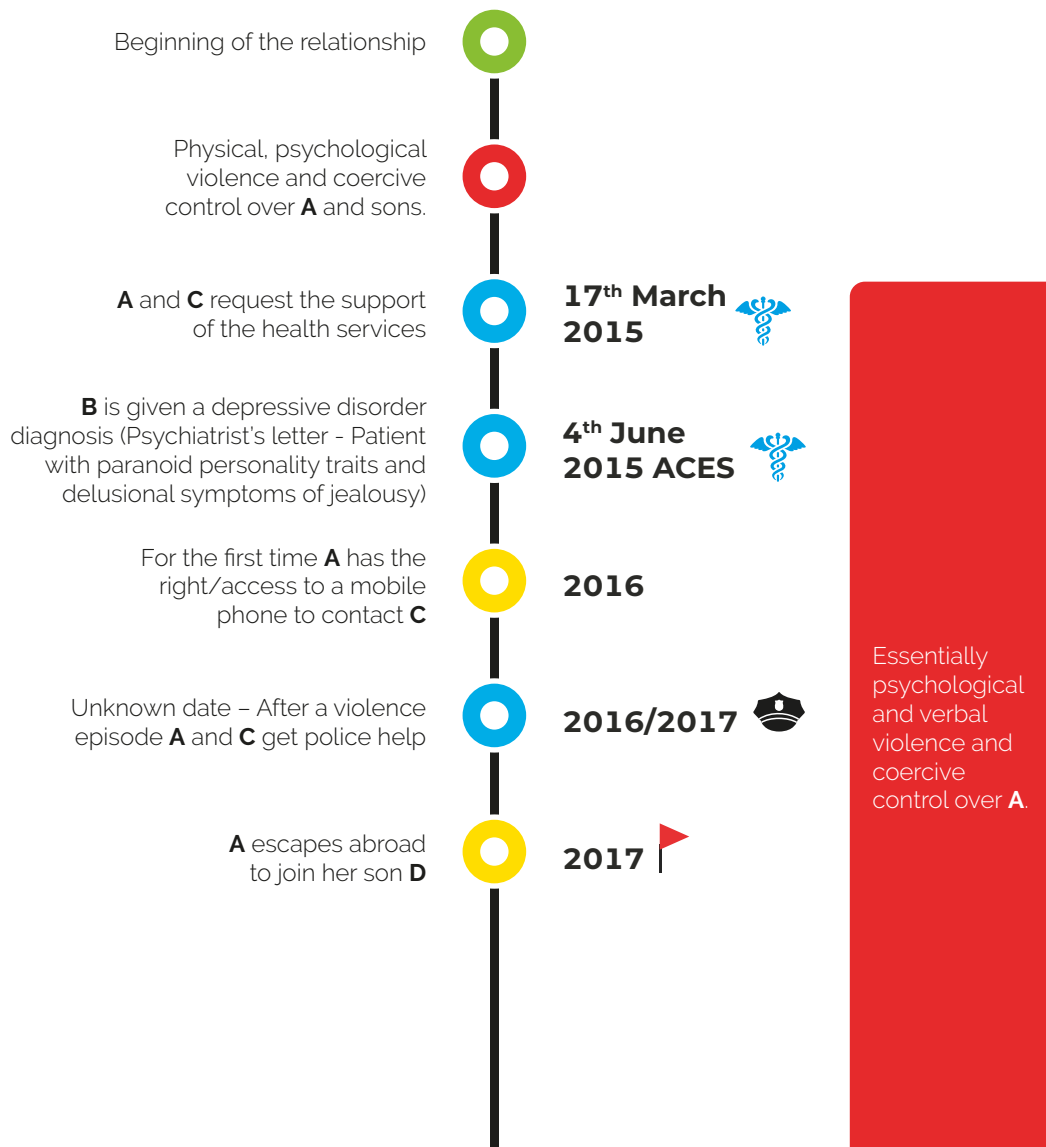


CHAPTER

# 5.

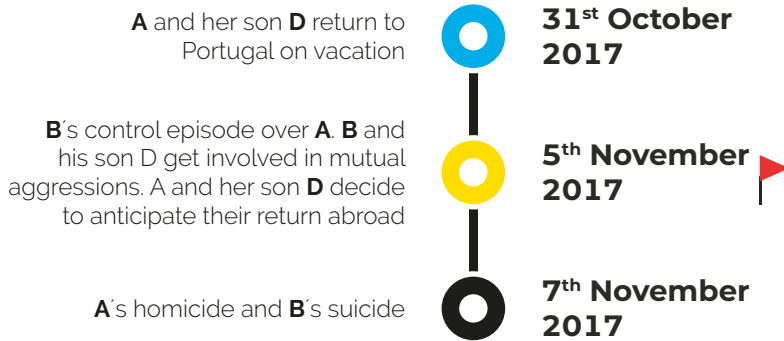
## Timeline of the case – graphic representation

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



DOMESTIC HOMICIDE REVIEW  
CHAPTER 5. TIMELINE OF THE CASE – GRAPHIC REPRESENTATION





**Legend**

- Beginning of the relationship (unknown date)
- Background/risk factors
- Opportunities for intervention
- Homicide
- Contacts with Police Forces
- Contacts with Health
- Risk triggers



Domestic Homicide Review

06.

Review



CHAPTER

# 06.

## Review

### 6.1. The story of B's violence and coercive control over A

The family life of this couple has always been marked by episodes of physical and psychological violence of **B** towards **A**, but also towards their sons (**C** and **D**). They became increasingly distant from their father and tried in various ways to protect and distance their mother from the situation she was in.

**B** was described as a "patient with paranoid personality traits and delusional symptoms of jealousy". The descriptions given by the sons are consistent with this diagnosis. He interpreted any action or omission by **A** as potential infidelity, such as not answering the telephone or being online, and even verbalised publicly that their youngest son was son of another person. This characteristic was known to the family, the health services and also the neighbours, since he would express it "to whoever would listen".

**B**'s control over **A** was so tight that, until **C** entered higher education, she was not allowed access to means of communication at a distance, which he then went on to monitor on a daily basis. **A** was forbidden from socialising and all her routines were closely scrutinised, becoming increasingly isolated from relationships outside the family unit.

Although her sons advised **A** not to let herself be controlled by their father, having sought to combat this control over the years, she would tell them that "it was better not to contradict him!". This was the survival strategy followed since **A** began to realise the risk she ran if she went against **B**. A strategy anchored in fear and which she adopted during decades of relationship with **B**.

The fear environment experienced by **A** is described by numerous victims and also by some researchers as "walking on eggshells"<sup>1</sup>. This constant fearful environment means

<sup>1</sup> Wiener, C (2017) Seeing what is 'invisible in plain sight': Policing coercive control. *The Howard Journal of Crime and Justice* 56(4): 500–515. page.510





that victims do everything they can to avoid disturbing or challenging the aggressor. They adopt strategies to help them feel safer by engaging in behaviours that may seem contradictory, but are really attempts to manage the dangerous situation in which they find themselves in.

**B**'s behaviour, in turn, can be characterised as one of coercive control over **A**, in that the following are present: intimidation (including threats and surveillance), isolation (including from family, friends and the world outside the home) and control (including of family resources and "micromanagement" of daily life). (Evan Stark, 2007)<sup>2</sup>

In late July 2017 the situation got worse and **A** went abroad with the help of her sons. This was the first time that she had been separated from **B**, who was taken by surprise because he only found out about the escape after it had taken place. However, **A** and **B** kept in touch by mobile phone and through social networks, and he adopted an apparently more conciliatory behaviour, but without ever giving up trying to know, at all times, what she was doing, who she was with or where she had gone. In October, when **A** came to Portugal, with a return to the country she was then living in scheduled to the 20<sup>th</sup> of December, **B** continued to control her, namely through the social media platforms. It was this behaviour that caused the incident occurred on 5<sup>th</sup> November as described above, which determined **A**'s decision to return earlier to her home abroad.

This would have been the moment that acted as a trigger for **B**'s behaviour. **B** felt he had lost control over **A**, killing her two days later, and then committing suicide.

## 6.2. Requests for assistance from A and opportunities for intervention - the importance of seizing every opportunity

We consider that there were at least two occasions on which **A** and **B** were in contact with entities with responsibilities in public action against domestic violence, which were opportunities for intervention that were not seized.

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<sup>2</sup> Stark, E. (2007) Coercive control. The entrapment of women in personal life. U.S.A: Oxford University Press – page 15



The first occasion involved the health services, in 2015, when **A** and her son **C** asked for support from the family doctor and when **B** was diagnosed as a "patient with paranoid personality traits and delusional jealousy symptomatology" and referred to psychiatric consultation, to whose treatment he did not comply with.

However, no record was made of the family conflict and no initiatives were taken that could have triggered a consistent intervention in its dysfunctional dynamics. As EARHVD already mentioned in the case report no. 4/2017-VP, "the National Health Service - SNS, in addition to the responsibility for the strict clinical management of situations of this type, it also has a mandate to investigate the socio-family determinants of these situations and take initiatives towards their resolution".

The second occasion was when **A**, **B** and **C** were present at the GNR station, to which **A** and **C** had fled to seek protection after another episode of violence. Although they had been there, no record of the incident was made, because, according to **C**, "they thought it was better not to file a complaint against **B**".

The presence of the aggressor and victim at the police premises, when there were suspicions of acts constituting a domestic violence crime, could not have gone unrecorded.

On the one hand, because the crime of domestic violence is that of a public nature (that is to say, the criminal procedure is not dependent on a complaint by the victim), so that if there is any evidence of such crime that can be included in the record, the denunciation is compulsory "for the police in relation to all crimes of which they become aware" [Article 242, no.1, paragraph a) of the CPP].

On the other hand, and as already recommended by the EARHVD, "any incident or intervention related with the possible existence of violence in interpersonal relationships should be recorded even if it does not give rise to the opening of a legal proceeding". This is because "the non-registration of occurrences and facts that may indicate, or show, the existence of interpersonal violence, in its multiple forms, means that any episode detected at a given moment is always a first or that it is an isolated, fortuitous act, and the gravity and extent of the violence remains unknown or concealed.

The inexistence or insufficient records, besides negatively influencing the assessment of the seriousness and the needs and type of intervention on each of those occasions, it also means the loss of an evaluative element which, *a posteriori*, may reveal crucial to evaluate the nature and seriousness of the assaultive behaviour in the criminal sphere" (case report no. 4/2017-VP).



In recent years **B** predominantly perpetrated significant psychological and emotional violence. Often, this violence is still not attributed the same attention and importance, nor is it understood and faced with the same level of seriousness and firmness as physical and sexual violence. All these forms of violence constitute a violation of the victim's human rights, are equally damaging to the victim's health, and are part of the descriptive elements of the domestic violence crime.

### 6.3. Final considerations

It is not unusual that only after years of physical, sexual and psychological violence victims are able react in order to free themselves from it and also to denounce it. For various reasons such as the support they start receiving from their children, who are also victims, when they reach adulthood. This situation is well documented in the present case, in which the voluntary testimonies of **A** and **B**'s sons to the EARHVD, constituted a significant contribution to this review.

When the victim is willing to free him/herself from the violent environment and fear in which he/she lives, by seeking help from a public, private or social sector organisation they can access, this opportunity must not be wasted. Otherwise, he/she will take refuge again in his/her own fragile personal defence strategies, giving up the fight to affirm his/her dignity. When this happens, because the history of violence is not documented, the homicide starts to seem an unexpected event. However, the review reveals its aetiology, namely the violence that preceded it.

In the present case, such a trail exists and the victim tried to use two *gateways* into the protection and assistance system to seek help: the health services and a police body. In none of them the situation was documented or she received an adequate response.

Two general conclusions should be drawn from this case:

1. The combat against domestic violence and victim support must be organised in such a way that the victims have a guarantee that their help request and the facts they report to any entity, including public services with responsibility in combating violence against women and domestic violence, are always registered and forwarded to the structure/entity which should follow up and respond to them. On the one hand, there should be no omissions of relevant events in the records, on the other hand, the professionals and the entities, who become aware of them





should assume the responsibility of activating the means of response in their sector or of direct the communication to the person(s) with that expertise.

2. It is not at the discretion of the police (insofar as they become aware of them) nor of any official (with regard to crimes they become aware of in the course of their duties and because of them) to decide whether or not to report facts that may constitute a public crime, as is the case with domestic violence.

Victims, often deprived of their freedom of movement and action, and often disturbed by the impact of violence, whether psychological, physical, sexual or economic, must be provided with accessible, discreet and safe ways to report their situation and to seek and obtain help, which give them the confidence that they will always be listened to, that their case will be directed to the appropriate body and that they will be supported in this journey from the very beginning.



Domestic Homicide Review

# 07.

**Conclusions**



CHAPTER

# 07.

## Conclusions

1. The present case deals with the homicide of a woman (**A**) by her husband (**B**), who then committed suicide. The family life of this couple has always been marked by episodes of physical and psychological violence from **B** towards **A**, but also towards their sons (**C** and **D**).
2. **B** was described as a “patient with paranoid personality traits and jealousy delirious symptomatology”, interpreting any action or omission from **A** as a potential infidelity, exerting such a tight control over her that, until her youngest son entered higher education, he did not allow her access to means of distance communication, which he then monitored on a daily basis.
3. Their sons tried to protect and remove the mother from this situation in various ways. She ended up, in July 2017, emigrating to the country where her eldest son was living, but maintained daily contact with **B**, by phone and social networks, who began to adopt an apparently more conciliatory tone but without never giving up trying to know and control her every move.
4. At the end of October of that same year, **A** came to Portugal on vacation with her son **D**, and **B** continued to exert a coercive control over her, with intimidation, social isolation and control, which culminated in a conflict involving the three of them, following **B**'s decision to *inspect* **A**'s mobile phone, accused her of “messing around with a brother-in-law” and the son of “not watching his mother properly while she was in (...)”. After which **A** decided to return early to the country where she was emigrated.
5. This was the moment that acted as a trigger for **B**'s behaviour who felt he had lost control over **A**, killing her two days later and then committing suicide.
6. There were at least two occasions on which **A** and **B** were in contact with entities with responsibilities in the public action against domestic violence, which were wasted opportunities for intervention:





- a. In 2015, with the health services, when **A** and her son **C** asked the family doctor for support, who then referred **B** for psychiatric consultation. He was diagnosed as a "patient with paranoid personality traits and jealousy delirious symptomatology" and did not comply with the prescribed therapy. However, no record was made of the family conflict, nor were any initiatives taken that could have triggered a consistent intervention in the dysfunctional dynamics;
  - b. With the police forces, when **A**, **B** and **C** were present at a police station, to where **A** and **C** fled to seek protection after another episode of violence. But although they had been there for some time, no record was made of the incident. This should have been done, because the crime of domestic violence is of a public nature. If there is information about facts that could constitute domestic violence, the report is mandatory "for the police in relation to all crimes of which they become aware" [Article 242, no. 1, paragraph a) of the CPP]; but also, because "any incident or intervention related to the possible existence of violence in interpersonal relationships must be recorded, even if it does not give rise to the opening of any legal proceedings" (EARHVD Recommendation, case report no. 4/2017-VP).
- 7.** Victims, often deprived of their freedom of movement and action and often disturbed by the impact of violence, whether psychological, physical, sexual or economic, must be provided with accessible, discreet and safe ways to denounce their situation and to seek and obtain help, giving them the confidence that they will always be heard. And that their case will be forwarded to the appropriate service and that they will be supported along the way from the very beginning.



Domestic Homicide Review

**08.**

**Recommendation**



CHAPTER

# 08.

## Recommendation

As a result of the present review, the EARHVD recommends:

- The annual plan for joint training on violence against women and domestic violence, provided for in the Resolution of the Council of Ministers No. 139/2019, of 18<sup>th</sup> July (published in the Official Journal -1<sup>st</sup> series, of 19<sup>th</sup> August 2019), should ensure the preparation of professionals from the various sectors to evaluate, recognise and combat psychological and economic violence, which is not always given the same relevance as physical and sexual violence, including behaviours that may involve coercive control strategies.

Lisbon, 20<sup>th</sup> May 2020

**Representative of the General Secretariat of the Ministry of Internal Affairs**

Dr. António Castanho (Report author)

**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.<sup>a</sup> Maria Cristina Mendonça

**Representative of the Ministry of Health**

Dr. Vasco Prazeres

**Representative of the Ministry of Labour, Solidarity and Social Security**

Dr.<sup>a</sup> Aida Marques

**Representative of the Republican National Guard**

1<sup>st</sup> Sargent Nuno Diogo (Non-Permanent Member)





## Approval of the Case Report No. 8/2018-AC

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

1. I hereby declare that all the members of the EARHVD agree with the contents of the previous report regarding the review of this case.
2. The review of homicides in a domestic violence context aim to contribute to improve 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.
3. In this specific case, the investigation and analysis focused on a long-term situation of physical and psychological violence, characterised as coercive control, which the victim and her sons have silenced for years and for which they tried to find personal coping strategies. They were not able to get the support they needed to break out of the violent environment in which they lived, the only two times they asked for help. It is presented a clear characterisation of the situation, analysed the intervention of the entities that had contact with the situation and are drawn relevant conclusions.
4. The review procedure defined in the EARHVD rules of procedure was respected.
5. The conclusions are based on the facts. The report is objective, reasoned and clearly written.
6. The recommendations presented are relevant and timely, in the light of the established facts and the identified shortcomings in the case.

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 Command.*

*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*
- *Inspectorate-General for Health Activities*
- *Inspectorate-General for Internal Affairs*
- *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.

25<sup>th</sup> May 2020

Rui do Carmo  
Coordinator of EARHVD