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15th January 2024

Dear Vickie,

Thank you for submitting the Domestic Homicide Review (DHR) report (Anne) for Fenland Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 13th December 2023. I apologise for the delay in responding to you.

The QA Panel felt the report was concise and to the point. The picture of Anne being shared amongst panel members at each meeting keeps Anne in the minds of the Panel which was commended and shows good practice. The research referenced to support the findings of the review was relevant and enhanced the overall analysis.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- Anne's voice is lost in the report at times. There is a lot of focus on the perpetrator and the reader fails to get a full picture of who Anne was, what her hobbies were or what she may have liked doing.

- The report does not follow the Statutory Guidance around the review process but leads directly into the background information of the victim and perpetrator. There is no explanation to the reader on what a Domestic Homicide Review is or its purpose or role. This should be amended prior to publication.

- This mother and son, Anne, and Ron, until the tragic event, were for all intents and purposes invisible to statutory agencies beyond routine primary care involvement due to Anne's long-term conditions. Anne and Ron were isolated within the community they lived. It is unclear to the reader what attempts were made by the Chair/Author to engage other siblings within the DHR. This may have provided greater insight into who the victim was and why she appeared

so isolated. The scope of the report feels limited and does not take into account what may have occurred to the victim/perpetrator during the whole period the victim was being cared for. The report appears primarily focused on the last week of the victim's life and the actions undertaken by the perpetrator to seek help. It is not clear to the reader if contact with other local Authorities were considered, given the victim's links to Scotland and Lancashire. It is not clear if David was ever approached given he may have been able to provide information around both Anne and Ron from 2013 when Ron started caring for Anne.

- There are 4 recommendations which relate to health, the health could have been summarised into one recommendation for health staff, for them to complete and put into practice safeguarding adults training; this is already a mandatory requirement. The safeguarding adults training would need to cover off all 4 recommendations.

- The Terms of Reference and further panel considerations sections do not follow the numbering template as per the rest of the report and the Executive Summary report has no numbering at all. The Terms of Reference (TOR) does not appear to include any reference to the impact COVID had on families, communities and services and the overall report does not appear to explore this in any detail. It is not clear from the TOR whether the family (i.e. daughter) was able to contribute to the TOR or if she was consulted in any way.

- Section 4 "*Terms of reference*" has single number paragraphs not following the numbering regime of the rest of the report. Numbers 1 to 17 and 1 to 8 are used which causes there to be duplicate paragraph numbers and makes cross referencing more difficult.

- 7.1 lists contributing agencies but does not state the nature of their contribution as required by guidance. It is not clear if all agencies listed provided an individual management report (IMR) or a report.

- The independence of the report authors is confirmed but that of the panel members is not. The police SIO is listed as a panel member who may have useful information to contribute but would not be considered independent of the case.

- It may be helpful to consider an additional recommendation relating directly to identifying carers who are victims of abuse (particularly coercive controlling behaviour) by the person for whom they care. Where are the opportunities for routine enquiry into how a carer is treated and whether there are under any undue pressure?

- The date the review report was completed is missing from the title page. Please can this be included.

- The victim's exact date of death is disclosed (para 12.4) which must be removed as it could risk the family being identified. Only the month and year is required.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel