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28th November 2024

Dear Victoria,

Thank you for submitting the Domestic Homicide Review (DHR) report (Jane) for Torbay Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 16 October 2024. I apologise for the delay in responding to you.

The QA Panel found the report to be well written and noted the effective engagement with the victim's family, which was conducted in a thorough and sensitive way. There was also good identification of the coercive and controlling behaviour that the victim had experienced from her ex-partner.

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:

- The pen picture of Jane in section 4 would be better placed at the beginning of the report. As it stands the reader does not get to know Jane until near the end.
- The date of death needs to be removed to ensure anonymity.
- Sections 1.1.9 and 1.11.1 state that at the time of writing, an inquest into the victim's death had not been held. This needs to be updated prior to publication. Has there been a conclusion to the inquest?
- The temporal scope was agreed at the first Panel, from 1 January 2020 until the date of death. There is currently no rationale for this start date, which should be added.
- 1.3.9 also states that the review concluded in February 2024, is this a mistake as the front title page shows as February 2023?

- 1.3.9 states that the Panel met three times, but there are no dates for these meetings, which should be added.
- The dissemination list needs to specifically include the PCC for Devon and Cornwall.
- There are no official postmortem results stated, which should be referenced if possible.
- The role of Adult Social Care is somewhat absent. It would be helpful to set out whether they had any involvement with Jane or Richard.
- There was no public health, mental health or suicide prevention representative on panel, to provide the lens of domestic abuse, self-harm, mental health and links to suicidality. The CSP may wish to consider this for any future reviews undertaken.
- The three key lines of enquiry are tailored to this case, but do not cover all the salient points and are somewhat sparse. There needs to be a more extensive list of lines of enquiry as per the statutory guidance.
- In the equality and diversity section the protected characteristics are listed but there is no reference to how these relate to Jane and how they have been considered within the review. For example, how the protected characteristic of disability has been explored in relation to Jane's mental health.
- 3.1.10 - in relation to the point about strangulation being a high-risk factor that should have led to a high-risk DASH assessment, there is no mention of how this should have also led to a referral to MARAC, and therefore also to an IDVA, which could be referenced.
- 3.1.33 – there is mention in the blue text that Jane's case was never heard at MARAC due to the risk of it never reaching the threshold to be referred. It should be clarified that it was not that her case did not meet the threshold, it was that the risk was not accurately assessed.
- Richard was known to be a perpetrator of domestic abuse with several previous partners but there is currently no consideration of this in terms of reference or recommendations. The QA Panel therefore suggest that further information on how the risks associated with this are now being managed.
- Please ensure all acronyms are clearly explained.

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