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Cllr Michael Hill OBE
Kent County Council
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18 October 2023

Dear Cllr Michael Hill,

Thank you for submitting the Domestic Homicide Review (DHR) report ('Diana') for Kent Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 6th September 2023. I apologise for the delay in responding to you.

The QA Panel are grateful for your comprehensive, open and transparent report into a challenging case, which highlights the links between suicide and domestic abuse. The Panel felt that the report reflected the lived experience of the victim, with good and respectful family engagement.

At 16:17, it was felt that the work of the transforming health and social care on cross-training could usefully be highlighted as good practice to be adopted more widely. Recommendations 8 and 11 were also flagged as especially helpful.

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:

- It would be helpful to make a final check on the draft for dates and references on academic research, but also on dates which may be relevant to the course of events (for example, 15.4.8 mentions that GPs were *recently* trained in DA and it would be helpful to know if this was before or after 'Dianna's death and the subsequent DHR process).

- 5.1.17 states "It is not understood at this stage whether officers did not ask the right questions or whether the training had not taken place to give the officers the tools to identify the behaviour". It would be helpful to clarify this.

- 5.2.1.12 The terms of reference might be trimmed down to focus on the specific agencies involved, and the references to homicides broadened to include suicide.

- 15.1.14 states: *Diana had prosecuted Nathan for the initial assault which had led to them separating.* It would be useful to reword this as *'Diana had supported the prosecution against Nathan'* as there are common misconceptions in the DA sphere about the victim rather than the crown prosecution service choosing to press charges.

- Section 15.4 analysis of Kent and Medway Clinical Commissioning Groups' IMR for the GP practice covers information-sharing, but might also look at whether the GP could have referred Diana to further help and support on DA. A specific action point for GP services may be appropriate. It may be worth considering a model of having a health representative who liaises with GPs and represents them at the multi-agency risk assessment conference (MARAC). This model is well established in Hackney and would be worth exploring. Likewise, an action around the role of schools in safeguarding children and information-sharing.

- It would have been good to see more probing of the prison service regarding how the perpetrator continued to contact the victim whilst in prison. It is understood that it may not be possible to obtain further timely information to feed into the report itself, however, an action point from this may be appropriate.

- There is a specific recommendation around information-sharing and MARACs which the Panel felt should be clarified: '*The MARAC process needs to consider that hearing from the perpetrator can be beneficial'.* The Panel felt that it may be appropriate to consider the background and mindset of the perpetrator, for example around drug misuse or mental illness. However, as a rule perpetrators should not be informed that a MARAC is in progress, in order to protect the safety of the victim.

- The Panel felt that the Action Plan could be strengthened on some points, where alerting or informing key parties of the issues might be sharpened into a request for action and a clear outcome. This may be especially relevant for national recommendations, where it may not be clear who should be held to account for delivery.

- As a drafting point, some Panel members found the Action Plan difficult to read with small typeface and dense columns of information. If there is a way to expand this, it may be helpful for future readers.

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.

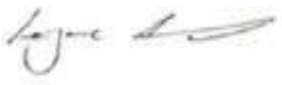
Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

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,



Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel