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Councillor Michael Hill OBE
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Sessions House
County Hall
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15th December 2020

Dear Councillor Michael Hill,

Thank you for submitting the Domestic Homicide Review (DHR) report (Dorothy) for Kent Community Safety Partnership to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 21st October 2020 therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agreed the feedback.

The QA Panel commented that this was a clearly challenging review and the DHR Chair and Panel have been sensitive in it's reporting. This is a probing, sensitive and non-defencive report. The engagement with the family was done thoughtfully with multiple attempts made to contact them and giving them the time they needed to grieve. Considering the daughter's view that a DHR did not need to be conducted as there was no evidence of abuse, the Panel felt that the DHR managed to sensitively examine the circumstances leading up to the death of the victim with the family wishes.

The QA Panel was pleased that research into dementia as a risk factor in DA was considered and that Dr Hannah Bows was contacted for advice on DA in older community. The review generally displayed good practice and the inclusion of the family in the dissemination list, links to publication websites, the inclusion of a DA Service on the panel and further probing of the CC IMR were specifically noted.

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 development:

- The front cover would benefit from having the month and year that Dorothy was killed.

- Para 7.2 would benefit from clarifying that domestic abuse was not a factor “prior to the homicide incident itself” and to recognise that the incident resulting in her death was an incident of domestic abuse.
- The Panel gained more insight into how things were for Derek rather than Dorothy, therefore the review was not balanced in that respect.
- It’s difficult as no concerns were raised or known, but a homicide took place in a domestic setting. An action for all professional agencies to have more training on older community and potential risks should be considered.
- The Panel are concerned where the pseudonyms came from and if the family approved, especially as a surname is also given, this applies to the victim, perpetrator and the family members themselves.
- Equality & Diversity – sex is always a factor and this is currently not addressed within this section. Dorothy’s dementia/disability should also be considered.
- States all policies are in place but it is unclear what these are. This needs to be expanded.
- TOR issues not discussed, for example, were practitioners sensitive to the needs of Dorothy and Derek, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- 7.12 states ‘from some interest research’ which does not fit the tone of the report.
- The action plan includes a couple of outcomes, but simply sending a copy of NICE Guidelines on dementia out to all Kent GPs has no outcome in terms of improving policy and practice – this is simply a process issue – who will be responsible for ensuring good practice across the GP community and how will anyone ever know?
- Panel
    - Job titles missing so it is unclear of the appropriateness of panel members in compliance with the statutory guidance
    - Appear to have missed important services such as specialist domestic abuse services, age / dementia specialist services to offer their expertise, insights and to further probe the information gathered – perhaps panel composition is something the Chair/CSP can consider more closely in future reviews
- It is unclear if the family offered specialist and expert advocacy to support their engagement in the process, e.g. were AAFDA leaflets were provided to the bereaved family?
- 2.4.3 Were the family offered another method (as opposed to just meeting the Chair/speaking to him on the phone) to engage with the process? They might, for example have found writing easier.

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 along 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.

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
Acting Chair of the Home Office DHR Quality Assurance Panel