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Stuart Douglas
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8 June 2023

Dear Stuart,

Thank you for submitting the Domestic Homicide Review (DHR) report (Mary) for South Cumbria Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 26th April 2023. I apologise for the delay in responding to you.

The QA Panel felt this review was clear, well-drafted and comprehensive, setting out the background to a challenging case. The review was sympathetic to the family and the voice of the victim comes through. It is accepted that it may be difficult to obtain a balanced view of Robert's character in the circumstances.

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: • 10.1 Should the

reference to [redacted] be to 'Mary'?

- It may have been useful to have had a specific Term of Reference (TOR) linked to routine enquiry about domestic abuse with older people as this appears to be a gap.

- In the TOR, the second police specific enquiry is *"To consider the issue of the missed referral to the DHR process."* While this is unusual for a DHR as it relates to what happened after the death, it may be appropriate in this case. Therefore, it would be helpful to explore more fully the circumstances in which the need for a DHR was not recognised (once the case had been identified as homicide rather than a double suicide). Specifically, the Panel are concerned the decision of the investigating officer in the case would have been subject to supervision by seniors and part of overall police process and feel that more should be said on why no-one in the police picked up the issue earlier.

- The DHR carried out does not incorporate a Safeguarding Adult Review (SAR). It is not made clear why, on the failure of police to identify the need for a DHR, no other agency identified the need for a SAR.

- Typo on executive summary: paragraph 6.17 should be 'needed to be moved into care'.

- 8:16. Without supporting evidence, it may be difficult to infer sexual abuse from dealing with incontinence.

- The role of Naomi in the case may be significant, as without her there may have been no information available to the authorities on what was going on in the relationship. It may be helpful to explore what more might have been done by the authorities in circumstances where no third party is already involved with the household.

- 18:45 and 18:78 while Mary did not disclose abuse, it may be helpful to explore whether the professionals involved should be enquired more closely. As drafted, there is a risk of appearing to be victim-blaming.

- The Panel had some reservations about including a copy of a page from the victim's diary rather than a summary and wanted to be reassured that the family were content with this.

- At 18:64 the Panel were especially concerned at the approach taken by GP's surgery and the absence of any 'red flags' about the case.

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.

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