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Dear Alison,

Thank you for submitting the Domestic Homicide Review (DHR) report (Nicky) for West Cumbria Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25th July 2023. I apologise for the delay in responding to you.

The QA Panel felt this is a good quality, easy to read report. It has a good section on equality and diversity and provided some intersectional analysis on the identities and protected characteristics of the victim and perpetrator, including possible barriers to accessing services.

The report also robustly challenged agencies Individual Management Reviews (IMRs) and their lack of effective analysis around equality and diversity. There was appropriate representation on the panel from specialist agencies and experts providing mental health and domestic abuse expertise.

There was a very good recommendation around local areas reviewing their Multi-Agency Risk Assessment Conference (MARAC) thresholds around intervention and escalation. This is a point often missed by DHRs and it can be critical in ensuring that cases involving escalating risk are referred to MARAC. The QA Panel found the recommendations to be clear and SMART, and there is an important focus in the report on cross borough working and the problems in continuity of service provision when perpetrators (and victims) move boroughs.

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 Independence of the Chair needs further clarification, and it would be beneficial to know which ‘large metropolitan area’ the Chair had previously worked (2.3.1).

- The victim and perpetrator’s initials are still to be changed for the agreed pseudonyms at points 4.15, 5.1.1, 5.5.6.

- To align with the Statutory Guidance, the age of victim at time of the fatal incident and their ethnicity should be stated in the Confidentiality section.

- The preface says that family are ‘considering’ providing a personal statement about Nicky and the impact of her death, so the preface needs to be updated either to include this or remove this holder.

- 6.1.9 reads contradictory as it highlights the prison surveillance response as good practice, yet 5.1.2 criticises the response to this surveillance.

- 4.14 – a brief footnote explaining what Urology, Gastroenterology and Ophthalmology are, would be helpful.

- Nicky had mental health issues, experienced suicidal thoughts and had a fall. These were all opportunities to probe further about any possible domestic abuse.

- Although MARAC was in place with good partnership attendance there were missed opportunities to refer Nicky to an IDVA. Contact with Nicky while Mark was in prison was not anticipated or planned for.

- As a result of the pandemic/COVID-19, MARAC meetings were moved to monthly meetings rather than weekly MARAC, which may have impacted negatively on the situation.

- Nicky’s voice seems somewhat unheard in the review, for example there is little about the trauma that Nicky must have experienced following the loss of her children to be cared for within the wider family network, this trauma has not been addressed in any depth.

- Mark was well known as a high risk to perpetrator of domestic abuse. There was no contingency planning when Mark was released at court for assault meaning he returned to live with Nicky without additional safety measures.

- The report refers to third party evidence to progress investigations but only refers to witness statements. There are many other sources of evidence that all agencies should be aware of. CCTV, 999 calls, ‘Res Gestae’, medical evidence, digital communications. We need to be relentless and inventive in securing evidence when we don’t have the engagement of the victim.

- The executive summary needs to be reworked as the content is not right. The appendices of the executive summary should be incorporated into the main report.

- The recommendations and subsequent action plan let down this otherwise well-constructed review. There are too many recommendations framed with 'soft verbs'- to promote, to seek assurance, to consider- and the action plan is underpopulated and lacking in measurable outcomes with much of it incomplete.

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