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Dear Alison,

Thank you for submitting the Domestic Homicide Review (DHR) report (Jessica) 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 the 11th October 2023. I apologise for the delay in responding to you.

The QA Panel concluded that the input from the family's neighbour was helpful to establish the background and the review found examples of good practice. The review is clearly written, and the chronology is easy to follow.

The QA panel highlighted the practitioner learning event during the DHR process which was an opportunity for learning and understanding the lived experience of Jessica.

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 exact date of Jessica's death is included. Only the month and year is required.

- There is a lack of explanation for the delay in the referral of Jessica's death to the Crown Prosecution Service.

- The Executive Summary contains more background information about Jessica and her family than within the overview report. This should be amended.

- Jessica's learning disability and the impact of this on the support she was given by professionals needs to be further explored. The review would benefit

from the inclusion of more third/voluntary sector expertise around the physical and mental disabilities that Jessica faced and the experience of elderly carers.

- A Learning from Life and Death Review (LeDeR) was completed in April 2022 by the North Cumbria Integrated Care Board (formally the North Cumbria Clinical Commissioning Group). The report does not state whether the learning and recommendations from this informed the DHR process.

- There was an over reliance on Jessica's parents to provide her care and support. There are suggestions from agencies that as they were growing older with health and care needs themselves, they struggled with providing this.

- Jessica was often not spoken to; conversation was via her parents who refused on her behalf. Whilst there was no finding of coercive control, this was not considered by the practitioners. The picture painted is of a difficult family but we gain no real understanding of why this was. The history of engagement over a longer period may clarify what happened in the final year of Jessica's life.

- Mental Capacity Act (2005) was not understood or acted upon. Jessica had previous capacity assessments because of her learning disability, however in the period leading up to her death, her capacity was presumed and never assessed.

- The equality and diversity section are brief. Sex, disability and age need to be further explored including the fact she was entirely dependent on her parents.

- It is stated that there was no criminal investigation, however there is no mention of the coronial procedures and/or if the case was subject to an inquest or had been opened and adjourned.

- There is a suggestion that this was a joint DHR and SAR however, the report goes on to state that a separate SAR was produced, and the recommendations of this was included in the appendices.

- The review attempted to engage surviving family members but shows how isolated the family were from their own community and perhaps the support they could have gained. Using non statutory agencies or community-based approaches should be considered and their availability.

- The difficulty in engaging the family and the support that Jessica might have needed needs to be explored in the action plan. For example, the inclusion of the homicide timeline in the case of elderly carers who cannot cope or elderly carers who were subject to abuse themselves, perhaps from the victim.

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