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Dear Alison,

Thank you for submitting the Domestic Homicide Review (DHR) report ('Ruth Fisher') for Cumberland Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 27th September 2023. I apologise for the delay in responding to you.

The QA Panel is grateful for your comprehensive report into a difficult and challenging case, and for the substantial changes and improvements to the original draft.

It is positive to see financial abuse recognised, and also the learning that it was rarely identified as such in the individual management reports (IMRs). The report includes some reasonable analysis around the dynamics of domestic abuse, including reasons why the victim may not have made further reports to the police including losing faith in the system, that she may have been using alcohol to cope with the abuse and the difficulty with accessing specialist DA support after having been signposted as the perpetrator was always at home.

There were positive contributions from the victim's sister which improved the quality of the report, and it was helpful to have a description of Dr Monckton-Smith's Homicide Timeline and specific analysis of how this relates to the circumstances of this case.

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:

- As a general point, more could be said from a health perspective about the role of GPs. Specifically, a patient declining medication and missing appointments should have been cause for concern. The lack of response to

Bill's presence and attitude, and an overall lack of professional curiosity, should be noted. This should be re-enforced with lessons learned and specific actions.

- There are no lessons learned or recommendations from a health perspective, while it is clear from the report this from a primary care perspective which is inadequate from the chronology, there is also no mention of emergency department and/ or hospital even to confirm that no attendances took place.

- The Report's five-year scope is explained, but the panel noted that the period 2002-2014 may have included a range of relevant incidents, including Bill's criminal conviction, which were relevant to the case.

- The financial abuse could be broadened to economic abuse to recognise the full behaviours that Ruth was experiencing beyond that Bill controlled her access to her bank account and money and to be in line with the definition introduced by the Domestic Abuse Act 2021. For example, this includes that Ruth's sister shared Bill took away her make up to stop her going out (13.5) and that there was no money on the gas meter which prevented a service from taking place (14.14). 17.3.9 rightfully recognises the improvements banks have made around responding to financial abuse, but it could also point to UK Finance's Financial Abuse Code, which was launched the month after Ruth's death.

- The review comments that the IMRs also did not recognise the financial abuse as such which is really interesting learning – this could be followed up with a resulting recommendation for the agencies, such as training on recognising economic abuse.

- Mental capacity is not mentioned, nor discussed in the report. There is some attempt to explore the need to use Safeguarding proceedings and research in relation to self-neglect. However, there is insufficient multi agency analysis to identify learning and how this might be different in the present time.

- At 15.5, the phrase 'clear self-neglect' may need qualification, given Ruth's mobility problems and inability to leave the flat.

- 1.1 includes the exact date of death. 10.2 reveals Bill's date of death. These should be removed. Only the month and year is required.

- The cover page is missing the month of death.

- The acronym HAWC is not explained until 14.42. HAWC also appears as HAWK at 8.3.5 and 8.3.8.

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