Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Gwynedd and Anglesey Community Safety Partnership
Council Offices
Caernarfon
LL55 1SH

23rd April 2024

Dear ,

Thank you for submitting the Domestic Homicide Review (DHR) report (Elizabeth) for Gwynedd Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 20th March 2024. I apologise for the delay in responding to you.

The QA Panel felt this was a good review which included effective Individual Management Review (IMR) practice supported by a curious and expert Panel. It brings a light onto an important area regarding abuse of parents by adult children.

Though there has not been any involvement from Elizabeth's family, it feels like there has been real efforts made to understand Elizabeth's experiences (for example, the information on Anglesey is helpful context at 10.1), and that there is good learning as a result.

There was a good use of research within the report and the glossary of terms and genogram included in the overview report is helpful.

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 to be made more apparent. The statement needs to say that she was independent of all agencies (para 4.1).

- It is mentioned that Elizabeth's daughter had shared with a FLO that she had expressed interest in taking part in the review (8.1), but it seems that the family were only invited by letters – could (or was) the FLO have been asked to facilitate contact?

- Age UK or Dewis Choice may have been beneficial panel members.

- In Appendix 2, 2.1 includes the date of Elizabeth's death. Only the month and year is required.

- The dissemination statement needs to be developed and should state that the reports will be sent to the Police and Crime Commissioner and the Domestic Abuse Commissioner.

- The timeline and contacts that Elizabeth, her husband and David had would have been easier to follow if there was a combined chronology. Currently, these contacts are presented by agency which makes it harder to follow.

- It is difficult to understand the meaning and purpose of the following paragraph, which could be further clarified. *"Given the privacy of the family, the panel reflected that analysis on this case may never have come to light. There would have unlikely been any review process on the previous incidents reported to the police, and thus the learning for families with similar issues and demographics in the Gwynedd and Anglesey area would not have been forthcoming.",* Section 9.1.9.

- The CSP may wish to double check a reference to the number of women killed in the UK which describes the number of women "*murdered"*, Para 11.2. Some of these killings may have resulted in manslaughter convictions which is not murder.

- The acronyms *"EOEL",* "*ISRO*"*, "WSP"* and *"WG"* in the Action Plan, are not explained.

- There were missed opportunities by police to undertake DASH risk assessments, on call out of domestic abuse incidents.

- There was a lack of professional curiosity and routine enquiry made by health staff with Elizabeth in her attendances at health appointments.

- A little development is required on the Action Plan. There are no milestone updates. Regarding the "*Lead Agency"* column, the entries for Health are populated more fully than are the entries for the other agencies. The national recommendations are not in the Multi-Agency Action Plan. They are listed separately. It would be helpful if the actions to implement these were listed.

- The Executive Summary is missing:
  - Confidentiality statement.
  - Timescales (only the dates of Panel meetings included).
  - Conclusion and lessons learned.
  - There had been previous calls to the police for domestic abuse incidents, involving David towards both his parents. It may be helpful to state the dates and type of abuse reported as this would seem relevant `.

- 9.4 Awareness raising on Isle of Anglesey - It would be helpful to clarify what the 'ADAPT model' is.
- The report requires a thorough proofread for typos, missing words and dates.

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