Home Office

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Isabel Allison
Community Safety Officer
Office of the Police and Crime Commissioner for Norfolk
Jubilee House, Falconers Chase
Wymondham
Norfolk
NR18 0WW

28th November 2024

Dear Isabel,

Thank you for submitting the Domestic Homicide Review (DHR) report (Val) for Norfolk Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 16 October 2024. I apologise for the delay in responding to you.

The QA Panel felt that Val's voice was heard throughout this review, and that the tribute from Val's mother and sister provided an insight into who he was and the adversities he experienced during his life. The report is thorough and sensitive, and included relevant themes. The report is also open and reflective, identifying lessons learned and correlating recommendations. The equality and diversity section is well addressed; specific protected characteristics were identified, and the barriers the victim may have experienced as a male experiencing domestic abuse were well considered.

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 layout should follow the template set out within the DHR Statutory Guidance where possible.
- The review requires a confidentiality section.
- Confidentiality is compromised by revealing the exact date of death, the exact date the police referred the death to the CSP and the children's genders. These references should be amended.

- The Panel felt that poor mental health, drug and alcohol misuse and the intersectionality with domestic abuse could be considered further within the review.
- There could also be further considerations and recommendations as to the impact of domestic abuse on the children.
- Information regarding the inquest is uncertain and it would be helpful to clarify whether the inquest process has taken account of the DHR. Paragraph 1.1.1 states that the Coroner's inquest has been opened and adjourned awaiting the completion of this review. However, section 1.8 states that the report has already gone to the Coroner, and paragraph 1.6.6 states that the inquest has been set for early July.
- The Mental Health Thematic Review of 'Repeat Presentations' is still ongoing, and the report currently lacks clarity on how the two reviews dovetail.
- Section 7 (Key issues arising from the review) should be completed.
- The second Term of Reference at Appendix A refers to a 'domestic homicide' instead of 'suicide'.
- The glossary would be better placed at the start of the report.
- All acronyms should be explained.
- A thorough proofread is required.

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

NORFOLK COMMUNITY SAFETY PARTNERSHIP

Office of the Police and Crime Commissioner for Norfolk
Jubilee House
Falconers Chase
Wymondham
NR18 0WW

18th of February 2025

Domestic Abuse Policy Team
Home Office
2 Marsham Street
London SW1P 4DF

Sent via email: DHREnquiries@homeoffice.gov.uk

Dear Sir/Madam,

Thank you for the advice and comments contained in the letter received from the Home Office DHR Quality Assurance Panel (QA panel), on the 28th of November 2024 regarding the DHR of Val.

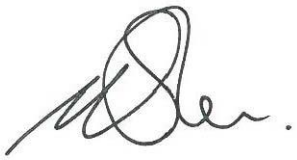
As Chair of the Norfolk Community Safeguarding Partnership, I am satisfied full consideration has been given to the points raised by the QA panel and addressed by the Norfolk panel members together with the independent chair and author of the review.

I am aware your office will not be able to amend the QA panel letter to reflect the changes that have been made to the final review without further submission to the QA panel. We have attached the QA panel considerations and this NCSP response to yourselves to demonstrate the changes made to that review. The changes made to the report are included in this letter.

Every DHR undertaken by our partnership champions the voice of the victim. This independent review process has ensured that Norfolk partners understood the circumstances of Val's death, how agencies work individually and together and established the lessons to be learned. As a partnership we will continue to apply these lessons learned to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

NORFOLK COMMUNITY SAFETY PARTNERSHIP

Yours faithfully,



Mark Stokes
Chair of the Norfolk Community Safety Partnership
Chief Executive of the Office of the Police and Crime Commissioner for Norfolk

DHR Val report changes following Home Office Quality Assurance feedback.

Area of Development	DHR Author/Panel Comment
The layout should follow the template set out within the DHR Statutory Guidance where possible.	*The author has reflected on the HO feedback and feels the report does follow the DHR Statutory Guidance.*
The review requires a confidentiality section.	*Now included at 1.4*
Confidentiality is compromised by revealing the exact date of death, the exact date the police referred the death to the CSP and the children's genders. These references should be amended.	*The author has amended the report.*
The Panel felt that poor mental health, drug and alcohol misuse and the intersectionality with domestic abuse could be considered further within the review.	*The author believes the report clearly identifies that poor mental health, drug and alcohol misuse and the intersectionality with domestic abuse has been considered in the following sections of the report.* *1.8.4, 3.2.9, 3.2.10, 3.2.38, 3.2.44, 3.2.45, 4.1.3, 4.1.4, 4.1.11, 4.2.11-4.2.14* *Recommendations 7, 9 and 11 relate to the above sections.*
There could also be further considerations and recommendations as to the impact of domestic abuse on the children.	*2.3.136 outlines the incidents the children were exposed to.* *Analysis 3.2.23 – 3.2.36 headed* The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home is explored. The author working with Norfolk CSP and Norfolk CSC have been made aware of the QA panels request for further consideration. To support the learning from this DHR this will be discussed in full at the Norfolk DASVG Children and Young People group to support partnership learning of the impact of abuse on children.

Information regarding the inquest is uncertain and it would be helpful to clarify whether the inquest process has taken account of the DHR. Paragraph 1.1.1 states that the Coroner's inquest has been opened and adjourned awaiting the completion of this review. However, section 1.8 states that the report has already gone to the Coroner, and paragraph 1.6.6 states that the inquest has been set for early July.	*Section 1.1.1 has been amended to reflect the QA panels comments.* *Section 1.7 in the report discusses the Coronial process. In section 1.9 the report identifies the report had been shared in confidence with the coroner for awareness purposes.* *At no point has the author detailed within the report the inquest was set for early July.*
The Mental Health Thematic Review of 'Repeat Presentations' is still ongoing, and the report currently lacks clarity on how the two reviews dovetail.	*This Menatl Health review has been completed* *The Thematic review findings have been added and found from 1.7.8 – 1.7.14. They have been integrated into the conclusion at 4.1.5 and the exec summary at 8.5*
Section 7 (Key issues arising from the review) should be completed.	*Please refer to Section 7 of the Executive Summary*
The second Term of Reference at Appendix A refers to a 'domestic homicide' instead of 'suicide'.	*Amended to 'death of Val'*
The glossary would be better placed at the start of the report.	*The author has amended the report and moved to Pg 6 of the overview report.*
All acronyms should be explained.	*The author has amended the report.*
A thorough proofread is required.	*The author and panel have fully reviewed this report and used both manual and electronic measures to ensure it meets the standards required for Home Office QA submission.*