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Marice Hawley
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29th May 2024

Dear Marice,

Thank you for submitting the Domestic Homicide Review (DHR) report (Chloe) for South Nottinghamshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 24th April 2024. I apologise for the delay in responding to you.

The QA Panel felt this was a well-written and sensitive review, which has made good efforts to understand Chloe's experiences. There was positive engagement by the author with Chloe's family, who contributed to DHR process and were supported by Advocacy after Fatal Domestic Abuse (AAFDA). The chronology is clear with dates included and there is very detailed information about historical contact with a number of services.

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 panel noted that the family could have been involved sooner in the process. This delay meant that support was not immediate for the family, which should be noted for any future DHRs.
- In the analysis section, there appears to be some insight from a friend of the victim, but it is not clear elsewhere in the report if a friend did contribute or if this information came through family members. There is also reference in the analysis section to a previous partner of 'George.' It would be helpful to clarify where this information came from.
- 1.3.7 states that IMRs were submitted by seven agencies and summary reports from two agencies. However, at 1.7.4, six IMRs are listed, three summary reports are listed, and one chronology only is listed. This

discrepancy should be resolved, so that the report is accurate as it is unclear how many IMRs etc were submitted and where information was therefore gathered from.

- In the analysis at 4.2, it would be beneficial if economic abuse was added – this includes the damage to Chloe's belongings which George carried out days before her death, which appears to be part of the reason she was in a hotel at the time. Economic abuse by her ex-partner is also mentioned at 3.5.6.

- During her time in hospital, Chloe made a few disclosures about past abuse, including serious sexual abuse, rape, and ongoing threats. Whist these issues were recorded within her records, there is no evidence of appropriate onward safeguarding concerns being raised in relation to them.

- Chloe experienced physical and digital stalking from her ex-partner in the period leading up to her death, which is not addressed in depth within the analysis.

- There could be further exploration of the impact of Chloe's physical health and neurological condition, particularly under the 'disability' characteristic in the equality and diversity section.

- There is no representation from public health/suicide prevention on this DHR panel. For future reviews into cases of suicide the CSP should consider this for panel composition.

- The CSP should consider including local public health and suicide prevention teams on the dissemination list.

- The date of death is evident in the chronology. There are also some instances where the sex of Chloe's children is revealed. These should be amended.

- It might be helpful to know if the police investigation following Chloe's death included offences other than the property damage.

- There is no mention at 1.8 as to whether the panel considered contacting the perpetrator.

- There are some inconsistencies around dates. For example, the data collection sheet says Chloe's death was in August 2021, but the report says 2020. 2.1.1 says Chloe and George separated in November 2020, but this should be 2019.

- In the analysis it would have been helpful to see the 'stalking' section also consider what appears to be post-separation abuse.

- The review could also have considered the challenges that the victim's family were navigating as they attempted to safeguard both their grandchildren and

their adult child whilst also managing services and contact with the abusive ex-partner. It would be helpful to consider what can be learned from their experiences.

- Section 6 could have considered the impact of suicide on the children.
- The report requires a thorough proofread.

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