Response to HO Feedback

Item	Action
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.	Noted for future reviews
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.	New paragraph added at 1.8.9 to clarify Friend 1 and George As above
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.	The lists have been corrected so that they are the same.
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.	Two paragraphs added at 4.2.40
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.	This is recorded at 3.4.5 – we have not made reference to this here. This was explored at the inquest and it was accepted that it was an oversight by the GP – this is recorded. A sentence has been added to make this more explicit

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.	The chronology sets out in detail the level of physical and digital stalking. This is referenced at 4.2.37. I do not think that it needs to be replicated again in detail. The heading has been changed to make clear that it was both physical and digital stalking.
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.	Two paragraphs added at 1.12.3
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.	More recent reviews undertaken by this Chair and Report Author in the county have developed good links and so this should be resolved for future reviews.
The CSP should consider including local public health and suicide prevention teams on the dissemination list.	CSP note for future reviews.
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.	I have removed the dates from the run up to her death, but we cannot remove the dates throughout the chronology or it becomes impossible to follow.
It might be helpful to know if the police investigation following Chloe's death included offences other than the property damage.	The family asked for the investigation to be closed and nothing further to be done. Sentence added at the end of 2.2.191
There is no mention at 1.8 as to whether the panel considered contacting the perpetrator.	Paragraph added at 1.8.10
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.	There is a typo on the data collection sheet. The date is 2020 2.1.1 has been amended
	Post separation abuse does not, in the view of the author, sit within the stalking section.

Response to HO Feedback

In the analysis it would have been helpful to see the ‘stalking’ section also consider what appears to be post-separation abuse.	The post separation abuse is referenced throughout section 4.2 and to have a specific section would become repetitive. A new paragraph has been added at 4.2.4 to make this clear.
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.	Noted for future reviews. Given the family’s ongoing grief it is not felt appropriate to go back to them and explore this new area with them.
Section 6 could have considered the impact of suicide on the children.	The research undertaken looks at the long term impacts that a child may experience if their parent has died by suicide such as substance misuse and mental ill health. The children’s grandparents are working hard to support these children and to set this out would be upsetting for all concerned. It is not felt that this would add sufficiently to the report to be of value.
The report requires a thorough proofread.	I have proof read but appreciate that I may see what I expect to see. If you want to have it professionally proof read we can arrange this – the cost will be about £300