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21 September 2022

Dear Lisa,

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

The QA Panel felt that this was a well-structured, sympathetic and thoughtful review, with well-designed terms of reference. The analysis is supported by relevant research and evidence, identifying some key points of learning around coercive and controlling behaviour.

Condolences are offered to the family at the start of the overview report and executive summary, and a special thanks given to her friends that contributed to the report, this kept Betty front and centre. It is highlighted as good practice that the report explores barriers for victims in disclosing domestic abuse and features comprehensive and specific recommendations which address key learning points

The Panel commend the engagement of three of Betty's friends who provided details on her personality, and her life, including her desire to start a family and the attempt to engage her family. The Panel also highlights the use of learning from other cases as good practice.

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 report states Betty rang her friends multiple times to tell them that Paul was attacking her. It would be useful to consider what they might have found helpful in alerting her to the dangers and to signposting her. This could also extend to how the rest of the community could be made aware of domestic abuse and the services available.

- There is no information about how they met, nor any analysis of any previous domestic history. It is important to understand the perpetrator's behaviour and identify if any intervention could have been made previously, for future learning.

- In the report, a friend mentions that Betty went to her GP in relation to her fertility issues. It would be useful for the report to look at whether questions were raised with Betty around how she was feeling and possibly the impact the fertility struggles were having on her mental health. For example, could a disclosure for support have been made. There was also further missed opportunities when Betty asked for medication to support her with her depression and anxiety and it is unclear if there was any conversations about why Betty might need the medication.

- It would have been good for the report to explore if the threshold for the multi-agency risk assessment conference (MARAC) was met and the missed opportunities, such as a Clare's Law Disclosure (Domestic Violence Disclosure Scheme).

- It would be useful to understand whether the local panel considered approaching the taxi firm that collected Betty for work every morning, her employer or her ex- partner, Tommy.

- Further reassurance is needed in the 'Independence of Chair' section. For example, it would be useful to understand if the Author put things in place to mitigate the fact, they are the CEO of a local DA Charity.

- It would have been good to see another DA Specialist on the panel as the Chair/Author has a specific focus and a second pair of eyes may have been helpful.

- At 8.1 it would be useful to state if the family were given the Home Office leaflet and if they were informed about support available from specialist and expert advocacy services.

- There is a lack of consideration given regarding protected characteristics – this section should be expanded on.

- The action plan lacks outcomes or any narrative on what has happened in respect of those actions that should have been completed. Further thought should be given to framing the recommendations in a way that will result in whole system improvement.

- The possibility that Betty had been subject to unconscious/conscious bias on the part of some professionals is not followed through in the proposed training. This point links to that about the ways in which perpetrators seek to shame victims in public and should form part of a system-wide learning approach. This should be addressed in future learning and recommendations.

- The report highlights that there was a missed opportunity for the police to utilise the cyber team within the force. The report goes some way to highlight the gaps in police training and makes suggestion for training on intimate image based abuse. The report could have gone further in addressing the police response to the technology-related abuse Betty experienced. It would be helpful for the report to address the number of support methods that can be utilised.

- At 10.6 the term 'committed' suicide is no longer recommended. An alternative could be 'died by suicide'.

- The date of death remains at several points throughout the report, allowing for easy identification of the victim in this case and should be removed.

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.

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,

Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel