

Interpersonal Abuse Unit 2 Marsham Street London SW1P 4DF

Leah Morgan Safeguarding Business Coordinator Cwm Taf Morgannwg Safeguarding Board Tŷ Catrin Unit 1 Maritime Industrial Estate Pontypridd CF37 1NY

13th July 2021

Dear Leah,

Thank you for submitting the Domestic Homicide Review (DHR) report (Shelly) for Cwm Taf Community Safety Partnership to the Home Office. I apologise for the delay in responding to you. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled 26th May therefore the report was assessed by a virtual process. For the virtual Panel, members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agreed the feedback.

The QA Panel felt the report was clear and easy to read and there was a detailed chronology of events. There has been good engagement with the victim's family, and this has added a lot to the review, and helps to humanise Shelly. There was a good level of involvement from Shelly's stepmother and father and evidence that their wishes were taken into consideration.

It is clear why the information presented in the review is relevant to the homicide. The recommendations reflect the learning points and there was good analysis of the lack of assessment relating to Shelly being an "Adult at Risk" and her being assumed to have adequate mental capacity.

The panel included a domestic abuse agency, mental health agency and sought advice from a specialist agency with regards to vulnerability related to alcohol and drug misuse and there was good use of research in the analysis. The Panel commended the 7-minute briefing and thought this did well to recap the summary of the case and its key findings.

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.

Feedback and areas for final development:

- The Panel have concerns about the chair's independence. It states at 9.2 that she
 is the Head of Children's Safeguarding for RCT County Borough Council (RCTCB).
 RCTCB are members of the CSP. This has been an issue raised previously which
 has not been addressed. The information on the chair also does not include a
 reference to any DHR training. In future the CSP must use chairs who are
 independent of the CSP and have the appropriate level of DHR training.
- Whilst there is discussion of Shelly's repeated requests for money, and this is linked to the coercive control perpetrated by Mike, this is not recognised as economic abuse, despite the evidence from Shelly's family that he was forcing her to do so. This is alongside the family's reports that Mike would take food from Shelly (48.14) and she had lost a significant amount of weight that she somewhat regain in prison, which she lost again on her release, that he would not let her back in her house (46.4) and had tried to sell her house to a friend (48.18). The report therefore fails to recognise a significant factor of the abuse Shelly was experiencing.
- The pseudonyms for the victim and perpetrator being in capitals all the way through the report is unnecessary and should be changed.
- To improve anonymity only the month and year of death is required.
- The equality and diversity issues have not been fully taken into account. The report refers to Shelly as being disabled (pg. 19, 12.4) but this does not really explore how this might have impacted on her ability to engage with service approaches or her overall vulnerability. There is also no discussion of sex in the Equality and Diversity section.
- It is not clear if the GP surgery and prison formed part of the review panel.
- It is noted that 'wider health services' did not enquire around domestic abuse. Health services seem to be frequently referred to throughout the report – as not having made correct referrals, not documenting properly, and failing to see the connections between coping mechanisms and cause and effect. They come across as treating the symptoms in front of them. The Panel supports stronger multiagency working but it is felt that there are some specific issues for health services to address here, particularly in relation to domestic abuse.
- The Pre Quality Assurance Assessment notes that the disability of the victim (she was blind in one eye) was not explored and the Panel feel that despite some small mentions of it, it still feels invisible and may well have increased her vulnerability.
- The theme of poverty is not explored enough and how this is a barrier for women leaving abusive relationships. The Panel think some research here would be a real benefit to the DHR.
- It appears that the family were only given a short period of time to read the DHR based on the visits on two consecutive days to discuss it.
- A review of the language is needed to ensure there is nothing that could be construed as victim blaming, for example it often stipulates that the victim 'refused' support, rather than declined it, or 'failed' to support the police case and 'demanded' rather than requested.

- There is no action update or detailed action plan to show who is leading on what and the timeframes for each. A detailed action plan needs to be published alongside the report.
- There could have been more exploration of assertive outreach beyond the alcohol treatment provision and of whether domestic abuse services writing to Shelly at an address she shared with Mike may have increased her risk and created a barrier to her accessing services.
- Please refrain from using the term 'toxic trio'.
- A thorough proofread is needed to correct typos, grammar and font changes.

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 <u>DHREnquiries@homeoffice.gov.uk</u>. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

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