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Cllr Clair Bell,
Kent County Council
Sessions House
County Hall
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11th April 2024

Dear Clair,

Thank you for submitting the Domestic Homicide Review (DHR) report (Beth) for Kent Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st February 2024. I apologise for the delay in responding to you.

The QA Panel felt that the report is written in a way that is both concise and sensitive to the victim Beth. The link between coercive control and the homicide itself is made clear and is supported with good research provided by Professor Jane Monckton-Smith.

The foreword from Beth's mother which opens the report is powerful. She chose Beth's pseudonym and agreed the others. There is representation from the local domestic abuse organisation on the panel.

As the report states there have fortunately been significant changes since the main timeframe of this review which would now affect policing activity, legislative changes regarding non-fatal strangulation, the implementation of DARA, the abolishment of harassment warnings and increased prosecution of coercive control.

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:

- It is not explained why it took the CSP a year to convene a DHR from when the perpetrator was convicted of murder and almost two years since he was charged. It would be helpful for the report to address this point.

- There is no mention of whether it was considered to invite Richard to take part in the review and it would be helpful to know Beth and Richard's ages.

- The following parts of the report may be contradictory:
    - The following statement as regards to the police is not credible and it is good that the reviewers appear to have recognised this (Para 15.55). *"The IMR author makes the point that each incident over the review period was properly dealt with, and that each incident was sufficiently far apart not to raise alarm bells about the eventual outcome.",* Para 15.53.
    - However, the report then states *"To those who worked with the family the clues to coercive control were not that apparent. There was a Non-Molestation Order taken out by Beth in 2015, there were reports of "controlling behaviour" from two people that Richard had relationships with. Otherwise the police callouts from 2014 are probably no more than might be expected from a difficult relationship breakdown.",* Para 16.14.

- The following statement is not accurate as the police did pick this up as they undertook DASH risk identifications. *"It is notable that no agency picked up that* [the victim] *was the victim of domestic abuse.",* Para 16.24.

- The following part of the report is incorrect as the victim did tell agencies that she had been abused by the perpetrator (see for example paragraphs 14.26., 14.49, 14.67); and we know that the victim obtained a non-molestation order against the perpetrator. ***"Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?*** *No allegations had been made at any stage and therefore no disclosures made.",* Para 16.24.

- There were missed opportunities across agencies with a children's focus (children's social care services, education and 0-19 health service) and the impact of domestic abuse on children. There was a lack of trauma informed approach, professional curiosity, information sharing, record keeping and onward referrals.

- There are instances where perhaps the word 'death' can be changed to 'murder', as the word murder is only written 6 times in the DHR and both words have a separate meaning.

- There was a lack of rigour from some agencies such as education, CAFCASS and children's social care to take Richard's word regarding Beth's mental health without seeking her voice and input into child protection procedures. There was also some victim blaming towards Beth.

- Paragraph 16.1 says that Richard controlled Beth's finances – this should be explored in more detail and recognised as economic abuse, alongside previously described economically abusive behaviours (e.g. that Richard cut off Beth's phone at 6.10 and had it disconnected post-separation at 14.22). The risk around Beth being able to buy out Richard on the mortgage very shortly before he killed her could also be explored further, particularly given that 16.8 introduces that Beth was not on the original mortgage.

- The Action Plan helpfully lists the actions required to be taken by agencies in order for the recommendations to be implemented. At least two of those recommendations start with "*All agencies*" but the police are not mentioned.

- The Action Plan does not have any recommendations from Individual Management Reviews (IMRs), assuming there were some.

- The equality and diversity section is underdeveloped and only identifies sex as protected characteristic in this DHR; it needs to take a more holistic overview of all the protected characteristics pertaining to this case, age, maternity, mental health and barriers to seeking and receiving support.

- There is no explanation of what the abbreviation 'SENCO' stands for, in paragraph 14:127.

- The executive summary could be strengthened if the review process information outlined in the template is included, as it goes straight into which agencies contributed to the review, so misses out important context around the review and Beth's death.

- The report requires a full 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