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3 August 2023

Dear Sophie,

Thank you for submitting the Domestic Homicide Review (DHR) report (Patrick) for Gloucestershire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 28th June 2023. I apologise for the delay in responding to you.

The QA Panel felt that the review is clearly presented, sensitive and shows a good understanding of domestic abuse, economic abuse and coercive control. The pen portrait focused the reader on Patrick's life before heading into the circumstances of the review and felt this was respectful to both the victim and the family. There is clear involvement of the family and their contributions in the review. The QA Panel felt that the equality and diversity section was addressed well in the report with the protected characteristics being viewed via and intersectional and ecological lens to have a better understanding of the lived experiences of those involved. It is also commended that Gloucestershire Health Care (GHC) commissioned and undertook a serious incident review (SIR) following the death of Patrick and shared learning and recommendations from this for practice.

The Panel note that there was local specialist representation from domestic abuse and sexual violence services, as well as LGBTQ+ and mental health organisations on the panel which is good practice. The Panel felt that the DHR displayed a relevant use of research with the review highlighting a number of learning points across the agencies involved and a welcome number of individual agency recommendations. The Panel also felt that the review displayed good practice to ask national helplines whether they had any contact with Patrick, in using Samaritans guidance for reporting on suicide and in highlighting that this is the 11th local DHR and other suicide-related reviews.

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, and at the request of the CSP the Executive Summary only may be published.

Areas for final development:

- Analysis
    - Whilst the review picks up on multiple strands of technology-facilitated abuse (5.1.4 and 5.1.5) and notes local awareness raising around this, it could have gone into more depth here, for example, questioning why, despite the clear risk of Jakob having access to Patrick's accounts/devices, several agencies recommended the HollieGuard App to him. Also surprising, the stalking via CCTV mentioned by Sarah wasn't picked up elsewhere. In addition to awareness-raising on recognising technology-facilitated abuse, local agencies need to understand how it impacts risk and safety-planning. Expertise on technology-facilitated abuse could have been sought.
    - The failure to consider charging Jakub with controlling or coercive behaviour is not explored and, again, the rationale around this should be made explicit and included in the points of learning.
- Action plan, learning and recommendations
    - There could have been further probing on Gloucestershire Domestic Abuse Support Service's (GDASS) assertion that 'there was no indication of suicide ideation.' Given Patrick had already made multiple suicide attempts, and disclosed suicidality to the other specialist gender-based violence service involved (GRASAC), did GDASS ever ask directly about suicidality? What is their usual practice around this? What support is available for team members on asking this critical question?
    - A recommendation could have been considered for Gloucestershire Police on ensuring understanding of non-fatal strangulation, given high-risk factor and recent new legislation – for example, does the force understand how it might present (e.g. 'choke', 'headlock'), how to ask right questions, what the new legislation enables?
    - It would be useful to understand why a Mental Health Homicide Review was not conducted as the victim was in receipt of mental health services at the time of the death.
- DHR participation
    - It is not stated if the family were offered the chance to meet with the panel in the information at 1.10 and would be useful to clarify.
- Language, formatting and typos

- Acronyms should be written in full the first time they are used
- Typos at 1.1.2 And 2.1.1 and footnote 31
- It is unclear why 3.2.39 onwards is highlighted
- If the decision is made to remove all elements of Jakub's personal referral info, then the item at 3.2.131 should also 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.

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,

Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel