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29 September 2020

Dear Anna,

Thank you for submitting the Domestic Homicide Review (DHR) report (Missy) for the Plymouth Community Safety Partnership to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 19 August therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office Secretariat summarised the feedback and the Panel agree the feedback.

The QA Panel commented that the report is well written, sensitive and appropriately critical. The recommendations are good, the chronology is presented well and appropriately commented on and appropriate themes have been identified.

Engagement with the family is evident throughout the report and the Panel appreciated the letter from the Chair at the start of the report. The information on Missy helps to humanise her and the information that her pseudonym was chosen by her family and that the perpetrator's pseudonym was chosen by the Chair is helpful context. The explanation for the delay was welcomed, as was the reference to the face-to-face apology from the police.

The Panel were pleased with the level of knowledge relating to DA which comes through in the report. The Equality and Diversity section which included references to the relevant research was also well received.

The Panel are largely satisfied that the amendments and Home Office feedback have been addressed or explained. However, there are aspects of the report which may benefit from further revision, but the Home Office is content that on completion of changes, the DHR may be published.

Areas for final development include:

- The letter from the Chair at the start is very nice, however, a pen portrait from the family may be appropriate with a chair letter as a backup if a portrait isn't provided by the family.
- 2.1 and 2.2 say 'death' but could be amended to murder to reflect what happened.
- The biography in the chair section may be more suitable as an appendix instead of featuring in the main body.
- Timeframe: the period covered needs to be clearer; there is very detailed information from 2007 with his ex-partner, which while relevant it offers more detail than necessary and should be summarised. The start of the relationship in 2010 would be an appropriate start for the scope with the main issues and similarities of before summarised.

- Missed opportunities:
    - Unclear why a MARAC did not take place in August 2009 when Missy was referred and whether the issue was resolved. This and other missed opportunities where Missy was assessed as high risk but no MARAC referrals were made need to be addressed within the analysis.
    - All cases discussed at MARAC should have an action for all organisations to put a 12-month marker on the case to identify any repeat incidents that should trigger a repeat referral into MARAC.
    - April 2013 Missy had a miscarriage however there is no information from health agencies in the timeline (only Police IMR), for example, was she seen for prenatal checks? If so, this would have been an opportunity for routine enquiry. Health agencies and HomeSafe could have done an IMR.
    - High risk DASH assessments should always lead to a referral into MARAC.

- Domestic Violence Disclosure Scheme
    - 17.7 and 17.35 – Claire's Law would not have been in place yet at that time. It is worth highlighting and explaining when officers in the local area were trained in this law change and provide assurances, they would know how to do a DVDS disclosure now.
    - Linked to the point above, 17.36 is unclear.

- April 2013 in the chronology and 17.20 refers to Missy's child as her son, when gender neutral language has been used throughout.
- Embed lessons learnt and recommendations within the report so it is easier to see how they came about.
- A recommendation on the December 2013 incident with the call handler should be made – *The call handler did not believe that Missy was at risk. It was graded as routine and a response in those circumstances is within 48 hours*.
- Although the victim wasn't referred to DA support, it would be helpful to understand what the pathways are now to show how a different response would happen now.
- The recommendations are good overall, but given the murder happened in 2013, clarity on which have already been actioned would be helpful and an action plan for remaining recommendations would be helpful.
- Economic abuse: there are examples of economic abuse in Alf's ex-partner Marie's experiences (such as breaking into her home, smashing her windows and Marie's worries he would damage her new partner's car), and in Missy's experiences of abuse by Alf, including threatening and very likely causing damage to her car, organising deliveries/taxis to Missy which she was not expecting, still having a key to her home without her knowledge and letting himself in. Whilst financial abuse is mentioned in Marie's DASH assessments, the analysis does not refer to economic

abuse experienced by either Missy or Marie. Given that we know that experiencing economic abuse in coercive control is linked to an increased risk of homicide (Websdale 1999) and how economic abuse can continue or start after separation (Sharp-Jeffs, 2015), this is a missed opportunity to recognise economic abuse. Inclusion of economic abuse could also be considered a key part of the training that is recommended in recommendation 6.

- Equality & Diversity – para 12.11 still refers to gender instead of sex. The E&D section also has not considered age or sexual orientation. Can these be clarified even if just to confirm they are not applicable to this case.
- Conflict of interest / independence – The DHR Chairs Personal Assistant is also an employee of AAFDA. Can clarification be given that Sue Haile was not also the allocated AAFDA advocate for the family?
- Chronology entry July 2009 – timings need to be reviewed as the Perpetrator's return time is before the initial 999 call.
- Overview section – would be worth mentioning the use of TecSOS and how this was not considered as an option. Perhaps another missed opportunity.
- Report needs to be checked for tenses to ensure the report is trauma informed and to minimise the risk of further trauma to the family / reader. The tenses should be written in the past tense, e.g. 17.31 *"Missy ~~is~~ **was** in fact a high-risk victim"*.
- Panel section – it would be helpful to have the representatives job roles as well as organisation to ensure of sufficient senior level as required by statutory guidance.

- Typos
    - Would be worth going through to standardize line spacing and the double space before some of the sentences to make it look cleaner.
    - Numerous missing full stops at the end of sentences.
    - 12.0 font is a different size and spacing is different.
    - The references after 12.12 need to be in a proper format, perhaps in footnote or using Harvard style in a bib at the end.
    - Would be useful to number the chronology and give the days, not just month and year.
    - Spacing between bullet points is inconsistent throughout.

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.

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,

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel