Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Jade Wilder
Community Coordinator - Prevention
Building Communities Together Team
West Berkshire Council,
Newbury,
Berkshire,
RG14 5LD

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Dear Jade,

Thank you for resubmitting the report (Karen) for West Berkshire Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in June 2022.

The QA Panel felt the review had good family engagement from the victim's mother and sister and were pleased to note that their comments on the draft have been incorporated. Despite Covid-19 restrictions, the perpetrator was involved in the review from prison. His comments were thought provoking and valuable and offers a unique insight.

Both Karen and Martin's mental health is explored deeply, the author acknowledges Adverse Childhood Experiences and how these factors would have impacted on the relationship. The author is clearly experienced in this area. The general conclusion is well written and provides an excellent summary.

The Home Office noted that some of the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

There are some areas of development listed below which the QA Panel would like the CSP to note.

- The removal of Karen's children was a significant event that impacted on her mental health. The author does note this in paragraph 390. Her mother describes it as having a 'traumatic effect' on Karen (paragraph 57). However, the details on this are minimal, not even the date of when this occurred was obvious. Greater exploration of the events at that time and how well Karen was supported is needed. The author states 'At the time of the removal of her children, Karen would have been offered birth parent counselling by an independent service as part of statutory requirements'. It would have been beneficial to look at the exact details of this to understand if the support she was offered was appropriate.

- There was nothing in the review explaining why Martin did not take any responsibility for his actions, the review would be strengthened by referencing research relating to domestic abuse and how perpetrators excuse their behaviour.

- Throughout the report the focus is on the perpetrator, with Martin's story coming through more strongly than Karen's. One example is when reviewing the contact with the West Berkshire NHS trust Karen's experiences are given just 2 paragraphs whilst Martin's involvements cover 11 paragraphs. There are also significant sections on Martin's experiences with Adult Social Care, Swansell Drug and Alcohol Service and The Priory.

- The Panel would have liked to see additional probing around what more could have been done to support Karen. There are references to her minimising the abuse and downplaying incidents, points 306 / 395. What more could agencies have done to help her see things differently.

- The Panel could have probed the individual management reviews (IMRs) in more depth, rather than accepting the lack of any recommendations. Both the GP practice and Sovereign have clear learning needs – 251. It would have been helpful to explore the domestic abuse issues in more detail, or document them more clearly.

- The chosen timescale of this DHR is questionable, looking at two years seems short and relatively superficial in an eleven-year relationship. The author notes several times events or interventions relating to Karen and Martin that occur 'outside the timescale covered by this DHR' (paragraph 237, 254, 258, 280, 291). If we are to fully understand Karen's lived experience and to make changes for the future, it is important to understand the whole story. The author does explore some of Martin's interventions outside the DHR review period (258) 'Although falling well outside the timescale for this DHR, the record of these contacts has been helpful in plotting the longevity of Martin's mental health and substance misuse difficulties'. Again, it is important the focus remains on Karen. If more from outside of the two-year time frame can be pulled into the review at this point, it would strengthen the review. If not, please note for future reviews.

- There is a new paragraph 30 in the Equality & Diversity section, which now includes women being at greater risk of domestic abuse, but this is inadequate as it does not cite any research to back up this assertion. The 2016 research by Standing Together Against Domestic Violence & London Metropolitan University would have been useful.

- The action plan is not outcome focussed and has no timelines. The outcomes column documents inputs, process and outputs and, whilst there are a couple of references to review, there is no indication of how any reviews of the action plan will be executed, how progress will be measured and how members of the public will monitor progress.

- The Executive Summary is still inadequate. it contains no summary chronology to ‘tell the story’ of the case, no Key Issues, and no Lessons to be Learnt. There is also no contents page.

- There are still some typos in the report which need to be amended.

We would be grateful if you could provide us with a finalised digital copy of the report with attachments 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 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