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NE27 0BY 2021

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Dear Lindsey,

Thank you for submitting the Domestic Homicide Review (DHR) report (Dean) for North Tyneside Safety Partnership to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 22nd September 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 review is open, honest and thorough, demonstrating a good understanding of the dynamic of domestic abuse (DA) and meaningful in considering the issues in the case, being critical of the agencies involved when needed. The family input in the report is significant, impactful and meaningful. It is clear that the family have been held as integral and have through the foreword in particular, been given a voice and help to bring Dean's voice to the review.

The report robustly challenges agencies on their practice and includes an ambitious action plan in order to make necessary changes to the multi-agency response to domestic abuse. The report feels appropriately probing of the agencies and their Independent Management Reviews (IMRs), not just taking the recommendations at face value, but identifying additional areas of weakness, lessons learned, and further recommendations identified. There is also a good use of research in the report, including Michael Johnson's typologies around perpetrators and victims who use violent resistance.

The equality and diversity section is thorough and addresses intersectional characteristics. It helpfully discusses the difference between intentional discrimination and the unintentional bias, which was a feature of agency involvement as many of those involved underestimated the risk and were unable to determine the

primary aggressor. The Panel note that the use of the victim's real name in this case is appropriate, given the family's advocacy and points set out at 3.3.

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 is complete.

Areas for final development:

- Chair and panel composition:
 - The panel had no voluntary sector membership, no specialist domestic abuse organisations represented, no specialist LGBTQ+ representation or substance misuse service. Involvement of these agencies in the panel would have enhanced the panel and consideration could have been given to asking domestic abuse and LGBTQ+ specialists to review the draft report for feedback.
 - The original Chair's independence is questionable, as he was previously the Chair of the Local Children's Safeguarding Board, and there are also concerns about the first report, given that 'significant gaps in the review' were identified when the second author took over (stated at 10.3). This should be noted to ensure chairs of future DHRs are suitably independent and experienced.
- Analysis:
 - The reasons for delay in the review are set out in 2.3 but this is not sufficient enough to explain a three-year delay. It would be useful to provide more detail on the timescales of the review.
 - Whilst the insecure financial and housing status of the victim is discussed, the review does not recognise the economic abuse James was perpetrating towards Dean that Dean's mother describes in her foreword, including keeping his bank card and not allowing him to have it, controlling the finances and she describes the rent not being paid. James also smashed Dean's tablet, serving to isolate him from friends online and potentially support for his alcohol addiction, and also controlled the electricity use. Research has found that gay men are more likely to report economic abuse so it is important this is made visible. This should be addressed further in the report.
 - Whilst the analysis is good, the review needs to consistently use references when referring to research here. For example, 16.1.8 states 'research also tells us...'; 16.4.2 states 'evidence highlights...'; 16.4.3: 'we know across the North East Hate crimes have increased'; 16.4.5: 'studies show LGBTQ+ people are less likely to recognise and name...'; 16.4.6: 'assessment of availability of specialist provision found only...'

without any references to evidence to support these. This needs to be addressed throughout.

- Action plan, learning and recommendations:
 - The action plan should be updated with the outcomes and information on the learning that has been acted on already. For a case with such significant learning it would be useful to provide assurances that recommendations have been implemented.
 - There was a referral to the local DA service for the victim of the homicide, but they never made contact with him. It would have been helpful to discuss best practice for domestic abuse organisations who experience a conflict of interest in referrals, i.e. the receipt of a referral for the partner of someone they are already supporting. It was helpful that the report identified the referral pathways for victims, but it would have been good to address if these pathways were effective to deal with situations where the agency available for support had a conflict of interest and it may have been most appropriate to refer the client elsewhere for support.
 - The report identified significant failings from the police and on pages 8 and 87. Whilst there is useful analysis around this it is unclear how this analysis has translated into actions specifically for the police around changing practice for future victims.
 - There is clearly an importance in the learning from this homicide around improving agency understanding of and ability to identify the primary perpetrator. This is referenced in the report and identified in the recommendations. It would have been helpful to reference available tools for doing this, such as the Respect male victim toolkit.
 - It would be useful to provide information on why parallel reviews were not shared with the DHR author. DHRs should promote multi agency learning and the CSP should take steps to understand and encourage this lack of multi-agency working.
- 6.1.1 mentions the Home Office leaflets but there is no information about advocacy leaflets having been provided when contacting the family. This should be clarified.
- Language, typos and formatting:

- The date of birth and precise date of death needs to be removed from the front page, 1.1 and page 54 in the overview report and the executive summary as only the month and year is needed.
- Paragraph numbers need to be added to the report.
- A proofread is needed as some typos 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. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

We are content that this report is not published due to significant parts of the report being in contravention of the Sexual Offences Act which affords lifelong anonymity for victims of serious sexual crimes.

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