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8 November 2022

Dear Daron,

Thank you for submitting the Domestic Homicide Review (DHR) report (Barbara) for the Gwynedd Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 26th October. I apologise for the delay in responding to you.

The QA Panel felt the involvement of Barbara and George's daughter Caroline has been helpful in assisting the read to understand their experiences and contact with services.

The inclusion of research that highlights the specific issues facing older victims and male victims was useful given the fact that George stated that he had acted in self-defence and had been a victim of domestic abuse for years. This is useful information, especially for those with limited knowledge regarding domestic abuse.

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:**

- Barbara had disclosed to medical professionals that she had been threatening and abusive to George; there is no evidence of any follow-up by the professionals to whom that information was disclosed. The recommendations regarding training for medical staff should include sections specifically about domestic abuse and older people.

- The panel could have benefitted from representation from an organisation like Age UK.

- More information is needed about the family's involvement. For example, there is no mention if they chose the pseudonyms used, if Caroline met with the full panel or Chair (it states she was met with but not who), if she had any comments on the draft, if she was given the opportunity to provide feedback on the Terms of Reference etc. There is also no information on how Barbara's sister was contacted and if she was provided information on advocacy etc. There was also little information on how George was contacted.

- Although the couple had spent by far most of their married lives in the Midlands, the review focused a lot on their lives in Wales which was only a fraction of that in the Midlands. The reasons for this are not made clear in the report. It leaves an impression that opportunities may have been missed to obtain a fuller picture of their lives together.

- Given that George was found to be a victim of Barbara's abuse, it would be helpful to clarify at 1.11.9 if this refers to the victim of the homicide. Similarly, the additional information about the homicide provided at 4.2.27 would be helpful to know earlier on.

- Barbara and George's mental capacity and capacity to consent is not addressed/analysed to any depth within the report.

- Barbara's deteriorating cognitive ability, confusion, memory loss, and issues with finance do not seem to have been passed on by her West Midlands GP practice to her new GP service in Wales despite registering quite timely on moving to Wales- this could have been a missed opportunity for both Barbara and George.

- In Caroline's victim impact statement, she said that hers was a family in crisis, shouting out for help. The QA Panel cannot see that the recommendations will ensure a family gain that support in the future. There is reference to where families could look for help in supporting their loved ones, but not to support themselves.

- The review raises the issue of professionals being faced with conflicting information and not knowing who to believe. It would be helpful if there was a specific recommendation in respect of this.

- Barbara had disclosed to medical professionals that she had been threatening and abusive to George; there is no evidence of any follow-up by the professionals to whom that information was disclosed. The recommendations regarding training for medical staff should include sections specifically about domestic abuse and older people.

- The recommendations include a number that could be classed as business as usual, based on training updates and ensuring an understanding of the legislative context in Wales. The action plan that follows is similarly focussed on inputs - training, awareness raising, public messaging and exchange of information. Neither the recommendations nor the action plan get to the crux

of this matter - that this couple's relationship, going back some 53 years, had been one in which George had been subject to DA, with Barbara exercising controlling and abusive behaviour, that may have been associated with undiagnosed mental health issues. There was a failure to grasp the complexity of the relationship or to understand that Barbara was a perpetrator of abuse, even though there is an instance of her admitting being in possession of a knife around George. The recommendations should explore how all those involved in caring for older couples could evidence their understanding of the complexity of domestic abuse in older couples, including the fact that the males in any partnership could be victims. Attendance at lunch and learn sessions, valuable as they are in imparting information, is not evidence of the change in policy and practice needed to avoid any such lack of awareness in the future.

- Some repetitive information has been removed although some still remains.

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.

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