

West Berkshire DHR responses to points raised in final letter from Home Office QA panel dated 22 June 2022

Area of Development	Evidence of Development Taken
Analysis	
<p>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 be beneficial to look at the exact details of this to understand if the support she was offered was appropriate.</p>	<p>This was outside the timeframe of the scope for the DHR and it is felt that extra detail is not required. The paragraph included is deemed sufficient.</p>
<p>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.</p>	<p>This was unable to be ascertained due to the reluctance to engage and therefore cannot be included.</p>
<p>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, Swanswell Drug and Alcohol Service and The Priory.</p>	<p>We do not agree with this statement.</p> <p>The perpetrator had more contact with services and therefore the Panel tried to understand what it was that lead him to commit murder as it provides a fuller picture.</p> <p>It is not possible to separate perpetrator and victim in the instance of this DHR.</p>
<p>The Panel would like 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.</p>	<p>The Panel were satisfied that everything was drawn out throughout this process which was appropriate within the scope of a DHR.</p>
<p>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 be helpful to explore the domestic abuse issues in more detail, or document them more clearly.</p>	<p>We do not agree with this statement. The Panel reviewed and analysed all IMRs thoroughly.</p> <p>The panel were not shy of sending IMRs back for further development if this was felt</p>

	appropriate.
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.	This point was not raised within the PQAA or QA process. Therefore, we did not have the ability to address this within due process.
Timescales	
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.	<p>The Panel felt two years was appropriate and proportionate based on the information. There has been issues raised outside the timescale for this point where it was felt by the Panel as important to include within the review.</p> <p>This will be noted in the future for future reviews.</p>
Action Plan/Recommendations	
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	<p>We are not required to publish the action plan and therefore members of the public will not be monitoring progress.</p> <p>The Building Communities Together Partnership retains responsibility for regularly monitoring and updating the action plan. Most actions are now completed.</p>
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.	This point was not raised within the PQAA or QA process. Therefore, we did not have the ability to address this within due process.
There are still some typos in the report which need to be amended.	The final report has been read and any typos have been corrected.