Home Office

Resubmission return template – North Worcestershire

Please complete this return template explaining if and where the evidence of development has been taken.

Area of Development	Evidence of Development Taken
The reason why both subjects were dealt with in the same review should be explained. It is unusual for a DHR to review a perpetrator's death, and so more information should be given about how the decision to include his death in this review was made.	Discussed with HO and Clarified in para. 1.1. The decision to deal with both subjects together was to optimize input from partner agencies who were likely to have dealt with both parties. **Home Office agreed this approach in an email 20 09 2021**
Various issues within the review would benefit from deeper analysis, to ensure all topics are explored sufficiently and relevant lessons drawn out. For example, there is no analysis around suicide or links to relevant research. There was no subject matter expert on the panel. Given this was a case examining two deaths by suicide, and their proximity to each other in time, this feels like large gap and missed opportunity. This would potentially be a key area for recommendations to be drawn from.	Suicide risk and research – 16.14 – 16.36 Subject matter experts - Suicide prevention team were invited to review and comment upon this report (8.3) and this is reflected in a new recommendation.
The panel also felt they did not get much of a sense of who the victim was from the review. There was a period when the victim was more settled – when she was employed and during her marriage. It might have been helpful to have understood more about this period to get a sense of her as a person. The victim's voice could be elevated within the review and their experience of domestic abuse should also be elevated as the focus of the report.	The review was unable to gain any further information about the settled period other than what was shared by agencies.
There could have been more exploration of how the victim's previous experiences might have impacted upon her interactions with services and decision making. For example, how being a looked after child, and having her own child during this time, impacted upon her life experiences. The panel felt links could be made between mental health, drug misuse, domestic abuse and the impact of adverse childhood experiences in adulthood.	Impact of lived experience and vulnerabilities explored in paras. 16.14 – 16.36
There is the suggestion that at some point within the temporal scope, the victim was employed – was any attempt made to contact her employer to understand if there were any disclosures in relation to domestic abuse and/or self-harm/suicidality? This might be a useful source of information in a review where there is very little and might also offer some useful learning.	The review was unable to identify the employer – now stated at para 6.2

The parallel reviews section neglects to mention the inquest(s). This would be a helpful inclusion in order for the readers to understand the status of the inquest and any decisions made by the coroner in these cases.	The coroner recorded verdicts of suicide in both cases on the following dates: Ashley Suicide (11 07 22) Ryan Suicide (25 11 21) Para 10.2
There are breaches of confidentiality such as date of death, initials used, and the sexes of children. These should be addressed. The initials SH appear at 16.10 and 16.31 – perhaps the real initials of the alleged perpetrator. These references should be removed for anonymity. This can also be found in the executive summary, for example at 7.9.	Amended
The recommendations are quite generic, further recommendations could be considered that are more specific to the case and relate to suicide or suicide prevention.	Recommendation added in respect of suicide.
This review would have benefitted from more than two panel meetings to enable a rigorous review. Learning events are welcome but should not replace formal panel meetings. The CSP might consider re-convening the panel to consider some of the issues raised here, in order to strengthen the review and its recommendations.	There appears to be a misunderstanding. There was a learning event and recall day which appears to have been interpreted as the only two meetings which took place. The panel met on four occasions (now clarified at para. 2.1)
The equality and diversity section needs to be further developed. The protected characteristics relevant to this review such as age and sex would benefit from further analysis.	Updated. See para. 11.2
The report should also detail who selected the pseudonyms and give further clarity on the independence of the Chair (e.g. which local authority they serve in).	Who chose the pseudonyms was included in the preface but has now been restated at 3.2 Chair details amended at 9.1
The decision-making process behind the decision to conduct the review requires further explanation, particularly regarding who made the decision, when, and whether this included input from specialist domestic abuse organisations.	Amended to reflect the Scoping Panel Meeting and the presence of West Mercia Women's Aid
Reasons for delays must also be clearly articulated. For example, the delay in sign off of 11 months by CSP. Section 2 also says the review was completed in November 2022 but the cover page is dated February 2023. There also appears to be a significant delay between this and the report being sent to the Home Office. These should be explained.	November 2022 was a typo. Paras 2.1 – 2.3 updated to reflect the delays and reasons for them.
The report requires a thorough proofread for typos	Completed.