SAFER CORNWALL

Mr Papaleontiou
Chair of the Home Office DHR Quality Assurance Pane
Public Protection Unit
2 Marsham Street
LONDON
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Dear Mr Papaleontiou

Safer Cornwall DHR5

Thank you for your letter of 06 December 2017 regarding the feedback from the Quality Assurance Panel following their review of the Overview Report for DHR5, which was considered on 25 October 2017.

I have now had opportunity to consider the feedback with colleagues and the DHR chair. We would like to thank the Panel for their recognition of the combined DHR and Mental Health Homicide Review and how this '*broadened the scope of the review*' and facilitated '*improved organisational engagement and learning*' and that external relevant expertise was sought to enhance the review.

We also welcome the recognition of the family's engagement and contribution; we will ensure that their tribute is included in the executive summary prior to publication.

To respond to each of the feedback points identified within the letter, prior to publication of the Executive Summary and Overview Report Safer Cornwall will:

Regarding use of hindsight in reviews - The panel felt that references to the Pemberton DHR as regards hindsight may need to rephrased as it could be interpreted to mean that the use of hindsight's in appropriate in reviews. The panel's view was that used appropriately, hindsight could be a useful tool for reviews.

We will re-word the reference to the Pemberton Review to separate from our view which is that hindsight is inappropriate in reviews; we recognise the difference and appropriate use of 'insight' as opposed to 'hindsight'.

The use of hindsight and hindsight bias should, in our opinion be avoided. As reviewers after the fact, we are in possession of information and knowledge not possessed by those people whose actions we are reviewing that they did not have at the time. Thus it follows that to criticise or make judgments about how they should have acted by using his hindsight we could apply would be to use an unreasonable bias or test.

In our review we have used a Root Cause Analysis methodology. This method cautions heavily against the use of hindsight. National Patient Safety Agency

guidance states that one should evaluate the decision or action taken at the time it was taken and given what was known or going on at that time, irrespective of the success or failure of the outcome.

It would be helpful if the report could provide additional detail to explain the period of time taken between the homicide incident and the report being submitted to the Home Office

We will ensure that this is met through an addition to Section One that explains the delays: this would include the complexity of the case, the detailed and lengthy engagement with family members, the need for external forensic psychiatry review and the need to resubmit the report following comments and feedback from the family on matters of accuracy and narrative content.

There is insufficient consideration of equality and diversity set out in the diversity section of the report (1.8)

The report states that none of the nine protected characteristics applied. The report provided narrative about the assumption that domestic abuse is most often perpetrated by men and that in this case it was a woman.

We are unclear as to what the Panel is requiring in addition and as such, we would welcome an expansion from the QA Panel on what would be required.

The review could have explored further the impact that the victim and perpetrator's professions had on them accessing health services and support and whether recommendations were required to address the findings

The report addresses this on page 69. We state that it was not clear that Adult B's professional status and background directly influenced those professionals working with her, but to some degree it was a factor in some of the interactions between her and health care professionals. This conclusion is drawn from our review of the evidence and in particular Dr McKenna's findings.

The panel queried why preventability on page 73 of the report is considered in the context of immediate threat

The Panel and Chair concluded that no one was aware of any immediate threat to the welfare of the deceased. Thus, given there was no indication previously that he would be harmed by his wife, we can only come to a view based on the immediate period and thus the period of threat, prior to the incident itself; the conclusion pivots on the introduction of hindsight bias or whether we retain the position of insight versus hindsight bias. We would welcome further steer from the Home Office Quality Assurance Panel.

The panel felt the report is lengthy and may benefit from being more concise. They suggested this could be achieved by reducing the detailed chronology at the end of the report.

We appreciate that the Home Office Guidance has been amended since the report was written and chronologies now no longer have to be routinely included

with the main report; we will remove the chronology from the report. However, given the learning from a chronology, we will publish this as a standalone document to aid learning in other areas.

This was a complex case that required detailed review and analysis. The family were engaged throughout and provided detailed feedback, requested clarification and we commissioned external expertise to respond, a reduction in the length of report would detract from this. The length of the report is a reflection of that complexity and the work of the panel in conducting a thorough review.

The panel noted there was no voluntary sector representation on the review panel.

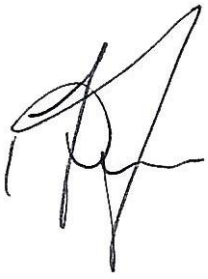
In Cornwall there are 8 domestic abuse and sexual violence specialist service providers which form the 'DASV Providers Group'. The group were formally invited as a member of the DHR Panel. The Group elected a representative who did not attend the Panel meetings. We have worked with the Group to address and understand that this has been resolved for further DHR Panels.

The panel agreed with the family's observation that the review panel may have benefitted from an experienced, professionally qualified forensic psychiatrist

The independent psychiatry expertise was provided via Dr McKenna (Niche Report). Dr Mckenna was commissioned to review the case and write a specialist report; we liaised with him throughout and drew heavily on his findings.
This was in response to ensuring the independence from local specialists in response to the family's request.

We look forward to welcoming you to the Safer Cornwall Strategic Board in February.

Yours sincerely



Paul Walker
Chair of the Safer Cornwall Partnership