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County Hall, Atlantic Wharf  
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3 January 2023

Dear Jenny,

Thank you for resubmitting the report (DHR7) for Cardiff Community Safety Partnership to the Home Office. The report was reassessed in November 2022.

The QA Panel felt the DHR is well structured, sensitive and empathetic, noting the acknowledgment of the loss to those who knew the victim, in particular her mother whose input was clearly valued and who chose the pseudonym for the victim. Family, friends and the victim's employer were consulted and contributed to the review, allowing for the events in the report to be viewed through the victim's eyes, which was stated as the aim of the review. The comments in italics throughout the report were also helpful in enhancing understanding of the whole process and the events leading up to Sarah's murder. The report also considered whether the GP could have been more professionally curious and showed immediate changes, such as introducing the Identification and Referral to Improve Safety programme which is commended as good practice.

The Home Office noted that some of the issues raised in the previous feedback letter following the first submission have now been addressed.

There were some aspects of the report which the QA Panel felt needed further revision. On completion of these changes the DHR may be published.

### **Areas of development**

#### **Equality and Diversity:**

- Age is relevant in this section given the twenty-year gap between Sarah and Adult A, though she was unaware of the extent of the gap. It is about identifying if there were any relevant effects of the actual age gap in terms of accessing and being offered services.
- The perpetrator has been excluded from this section. It is important to also understand the protected characteristics for offenders to get a clear sense of possible barriers they may have faced and aid learning. The DHR Statutory

Guidance is clear – “*where there is evidence to suggest that a person is responsible for the death of the victim their confidentiality should be set aside in the greater public interest.*”

**DHR participation and contribution:**

- It is unclear if advocacy was offered to Sarah’s friends, who understandably found it too emotionally difficult to engage with the review. If the Chair did offer advocacy this should be documented in the report.
- It seems from 6.12 that there was only one attempt made at contacting Adult A, to which he did not respond. It would be useful to clarify if any other attempts were made.
- The victim’s mother should be given an opportunity to check for accuracy of information, before the Home Office quality assures it. This would mean that if there was something wrong that ought to be amended, it can be done before quality assurance. She should also be reminded of the availability of specialist advocacy at this stage.

**Panel and Chair representation:**

- There is insufficient information on the organisation that the chair was a special advisor to (6.18) and the ‘international investigation facility’ he belongs to (6.19). These should be specified. If the Chair is unwilling to name the organisation and the international investigation facility and if there is no requirement for him to protect their identity, then reference to these should be removed from the report.

**Analysis:**

- Given that Adult A did not work and that he had already moved in with Sarah by the time he murdered her (1.16), it would be relevant to know if he was financially reliant on her, or if economic abuse was considered in the case. This should be communicated in the report.
- Considering the DHR was completed in 2021, the report could be updated to refer to the homicide timeline developed by Prof. Monckton-Smith as it seems relevant to this case.

**Learning and recommendations:**

- The CSP should make a recommendation about MATACs. The MATAC is about disrupting perpetrator’s actions. Given he was a serial perpetrator making a recommendation around use of MATACs could be useful.
- The CSP should ensure that the victim’s employer has a suitable policy and service for its employees who suffer domestic abuse. And if the employer does not have these, then the CSP should offer them assistance to create them. This should be documented in the report.

We would be grateful if you could provide us with a finalised digital copy of the report with attachments 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](mailto: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 [DHR@domesticabusecommissioner.independent.gov.uk](mailto: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