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Sarah Fines
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3 July 2026

Dear Sarah,

Thank you for submitting the Domestic Homicide Review (DHR) report (Chloe) for Huntingdonshire Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 20 May 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

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 and the feedback form 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.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, 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,

Home Office DHR Quality Assurance Board

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Chloe
COMMUNITY SAFETY PARTNERSHIP	Huntingdonshire
DATE REVIEWED BY QA BOARD	20 May 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• There is clear involvement of the family throughout the process, including the provision of information and support, and the opportunity for family participation within the panel process. • It is positive to see acknowledgement where agencies had already identified and implemented learning prior to the conclusion of the review. • The consideration of coercive and controlling behaviour through a holistic lens rather than solely through recorded incidents is also appropriate and evidence informed. • The inclusion of relevant childhood experiences, trauma and adverse experiences for Keith assists understanding without excusing responsibility for the homicide. • The repeated identification across multiple DHRs of out-of-hours mental health provision disparities is important and demonstrates recurring thematic learning. This is a strong example of where the review appropriately highlights systemic concerns beyond a single case.
FEEDBACK FOR FUTURE DHRs	• Consideration should be given to ensuring all recommendations are fully SMART, with clear timescales, ownership, review mechanisms, completion status, and evidence of how effectiveness will be measured.

	DHR SECTION	**DHR QA BOARD FEEDBACK (improvements required before publication)**
1	Title Page	No amendments required.
2	Contents Page	No amendments required.
3	Pen Portrait	No amendments required.
4	Condolences	No amendments required.

5	Confidentiality and Anonymity	No amendments required.
6	Terms of Reference	No amendments required.
7	Equality and Diversity	This section would benefit from moving beyond a largely descriptive overview of legislation and national statistics to include greater analysis of how equality, diversity, vulnerability, and protected characteristics specifically impacted Chloe's lived experience, agency responses, help-seeking opportunities, and potential barriers to support. Whilst neurodiversity and mental health vulnerabilities are referenced elsewhere within the review, stronger consideration could be given here to how these may have increased vulnerability to coercive and controlling behaviour.
8	Background Information	Please consider refining the distinction between factual background information and later analytical commentary, as some sections begin to move into analysis rather than remaining descriptive.
9	Combined Chronology	Consideration could be given to reducing some of the narrative detail where extensive descriptions begin to move into analysis.
10	Overview	Please consider adding further exploration of non-fatal strangulation within the review, given Chloe's earlier experience in a previous relationship and the eventual cause of death.
11	Analysis	• The analysis would be strengthened by ensuring the distinction remains clear between what was known to agencies at the time and what became known after Chloe's death. This will help avoid hindsight bias while still allowing the panel to comment on missed opportunities for professional curiosity. • The references to Keith attending appointments, Chloe missing appointments, his carer's allowance claim, and family observations of monitoring and isolation are important and should be explicitly linked to coercive control and cumulative risk.
12	Conclusions	• Please ensure there is clear distinction between evidenced fact, family perception and panel opinion. • Please consider editing to avoid repetition between paragraphs 4.1.9–4.1.12, as similar themes are revisited several times.
13	Lessons learnt and recommendations	• Please consider whether the recommendation regarding protected characteristics within the DARA process should also reference cumulative vulnerability and neurodiversity, given the themes identified throughout the review. • The section would benefit from a clearer distinction between "lessons learnt" and broader contextual or research information, as some passages become descriptive rather than directly linked to learning arising from this case.

		• Some recommendations would benefit from being strengthened further into a SMART format by including clearer timescales, ownership, expected outcomes, and methods of assurance or audit. For example, recommendations relating to GP domestic abuse enquiry and information sharing pathways could specify how compliance or effectiveness will be monitored.
14	Timescales	No amendments required.
15	Involvement of family / friends / community	No amendments required.
16	DHR contributors	No amendments required.
17	DHR Panel	• Please explain why Adult Social Care involvement was limited and to explicitly state whether all IMR authors were independent of direct case involvement. • Please outline how many times the panel met.
18	DHR Author	No amendments required.
19	Parallel Reviews	Care should be taken regarding the level of forensic detail included concerning fatal strangulation, as some of this may be more detailed than necessary for the purpose of the review.
20	Dissemination	No amendments required.
21	Action Plan	• The action plan would benefit from greater consistency and clarity. Several sections appear incomplete or incorrectly formatted, including the insertion of “Peterborough Women’s Aid – Lead role” within the repeated mental health certificates recommendation, which requires clarification. • Some recommendations do not contain target dates, limiting the ability to assess progress and accountability. Please ensure the recommendations are up to date prior to publication.
22	Has there been a request to withhold publication?	No requests to withhold publication.

	If Yes, include the reason for the request. Is it proportionate and appropriate?	
23	Any other comments	• Please conduct a thorough proofread to correct minor typos throughout the review. • Overview report - **DASH** – Domestic Abuse and Stalking and Harassment risk assessment – please add ‘honour’-based abuse. • Please add DARA to the glossary.