Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Amanda Gregory
Strategic Manager for Regulatory and Community Safety Services
Isle of Wight Council
Jubilee Stores
The Quay
Newport
Isle of Wight
PO30 2EH

4 May 2022

Dear Amanda,

Thank you for resubmitting the report (Mrs Fleming) for Isle of Wight Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in April 2022.

The QA Panel commend the CSP for doing a DHR despite the fact the case falls slightly outside the normal cause of death criteria. The contributions from Age UK are really positive and the family, some friends and neighbours' views were sought and considered. There was a good effort to think creatively to involve a wide range of agencies and people who might have been able to contribute to the review (i.e. the gardener)

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

The view of the Home Office is that the DHR may now be published.

There are some areas of development listed below which the QA Panel would like the CSP to note.

- Equality & Diversity – This section is missing entirely from the DHR. There are multiple E&D elements of relevance to this DHR – age, sex, disability. The alleged perpetrator stated he did not feel able to seek help, this should be considered in relation to the protected characteristics and how these influenced any barriers he may have faced.

- The pseudonyms do not appear to have been discussed or agreed with the family.

- There is a perception that this issue is just the responsibility of primary care. The review focusses on the actions of the medical professionals that both the victim and her son engaged with (albeit in a very limited way) but there is no

discussion or recommendations around the wider responsibilities of agencies in supporting carers, or those that are struggling. It cannot just be the responsibility of primary care to think about ensuring that older people and their carers understand that they can ask for help and where that might come from. The fact that others in the community 'thought she was already dead' and that smells were noticed coming from the house suggests there is work to do in the community, local authority and with broader agencies and third sector partners to ensure older people and their carers do not fall though the gaps in the way that this couple did. There is a brief mention of possible dementia in the second coroner's report but if neither are accessing any services that would not necessarily be picked up (and if the son did not recognise the signs of this).

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. 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.

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