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Community Safety Partnerships Policy Officer
Enforcement and Community Safety
London Borough of Barking and Dagenham
Barking Town Hall
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25th November 2025

Dear Jade,

Thank you for submitting the Domestic Homicide Review (DHR) report (Christine) for Barking & Dagenham Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 5th November 2025. 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	Christine
COMMUNITY SAFETY PARTNERSHIP	Barking & Dagenham
DATE REVIEWED BY QA BOARD	5th November 2025
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• There was a very impactful pen portrait for Christine, provided by her daughter. • The review was conducted through an intersectional and ecological lens and the recognition of both has added richness to the review. • Christine's employer was actively involved in the review and provided valuable information that enriched the report. • Consideration of local case review learning demonstrates a commitment to continuous improvement and application of past lessons. This was commended as best practice. • The analysis is very well presented with learning points clearly linked to analysis. • The panel was made up of statutory and third sector agencies which was positive. There was a leading African third sector led organisation on the panel to provide an insight to Christine's ethnicity and cultural background.
FEEDBACK FOR FUTURE DHRs	

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

5	Terms of Reference	The terms of reference are currently in an appendix and should be in the body of the report.
6	Equality and Diversity	No amendments required.
7	Background Information	• No information was received from adult social care. The review should explain why this was the case and consider making a recommendation to adult social care regarding the lack of information shared. • The review does not include an update on the coroner's inquest. It would be helpful to add a section summarising the outcome or status of the inquest for completeness. • Please replace the wording "subject of a child protection register" with "subject to a child protection plan". • It is unclear whether the case was heard at MARAC. The text suggests this pathway but does not confirm. It would be helpful to explicitly state whether the case was heard at MARAC and provide details if applicable.
8	Combined Chronology	No amendments required.
9	Overview	No amendments required.
10	Analysis	No amendments required.
11	Conclusions	No amendments required.
12	Lessons learnt and recommendations	• Adult child-to-parent abuse is not explicitly recognised, and further detail should be added on this where possible. • More information on the insufficient collaboration between agencies and on Christine's role as a carer for her son with enduring mental health issues should be added and acknowledged in greater detail. • There are a high number of recommendations, some of which could be consolidated or removed were unnecessary.
13	Timescales	No amendments required.
14	Involvement of family / friends / community	No amendments required.
16	DHR contributors	Information is missing in the training table from the London Ambulance Service and Children's services. Please add this.
17	DHR Panel	No amendments required.

18	DHR Author	No amendments required.
19	Parallel Reviews	As referenced above, it is stated that the death of Christine was referred to the HM Coroner and the inquest awaits the completion of this DHR. The report states a further pre-inquest hearing was planned for November 2024; please update the report accordingly.
20	Dissemination	The dissemination list does not include the family of Christine or the Domestic Abuse Commissioner's Office, which should be added.
21	Action Plan	• Where actions are marked as "completed", the outcomes are not stated clearly. Each action should specify what overall change or improvement has been achieved. Without this, it's difficult to measure impact. • The action regarding the IDVA and lack of risk planning is critical in this case. The current wording does not provide assurance that risk planning gaps will be addressed. Please therefore strengthen this action where possible. • References to target dates in 2023 present an opportunity to seek assurance that actions have been completed and outcomes achieved. The QA Board suggest adding a mechanism for progress verification. • It would be helpful to strengthen the recommendation on child-to-parent abuse as the current recommendation is somewhat vague. It should be clearer and applicable across all agencies, emphasising recognition, response protocols and training.
22	Has there been a request to withhold publication? *If Yes, include the reason for the request. Is it proportionate and appropriate?*	No request to withhold publication.
23	Any other comments	The QA Board noted that this is the first homicide of a mother by her son in Barking and Dagenham and therefore provides an opportunity to raise awareness of child to parent abuse.