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29th October 2025

Dear Hannah,

Thank you for submitting the Domestic Homicide Review (DHR) report (Kathryn) for North Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 30th September 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;
- 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	Kathryn
COMMUNITY SAFETY PARTNERSHIP	North Somerset
DATE REVIEWED BY QA BOARD	30th September 2025
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• There was an impactful and moving tribute from Kathryn's best friend Annika, which provided an insight to Kathryn, the adversities she experienced and losses she experienced from a very young age. • Condolences were offered to the family and friends of Kathryn. • A revised *Safeguarding Adults Concern Form* now prompts professionals to clearly state required actions • North Somerset Council has now hired a consultant to embed trauma-informed practices and drive systemic change. • Police have implemented a system to detect tracking software on phones, addressing previous gaps.
FEEDBACK FOR FUTURE DHRs	

	DHR SECTION	**DHR QA BOARD FEEDBACK (improvements required before publication)**
	Title Page	The month of death is required as per the statutory guidance. Please add this to the title page of the overview report and executive summary.
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	No amendments required
6	Equality and Diversity	No amendments required
7	Background Information	At 12.8 it reads that Kathryn's response to being shown kindness and affection 'made her vulnerable to approaches' (6.3 in Executive Summary). Replacing this wording with 'made her the target of abusive men' may be more appropriate.
8	Combined Chronology	It is suggested at 15.5.29 that a Domestic Violence Protection Notice (DVPN) could not be used because Kathryn and Brent did not live together. It should be noted that a DVPN could have been used and may have been effective in helping build Kathryn's safety.
9	Overview	No amendments required.
10	Analysis	The analysis creates a clear sense of hopelessness, building a picture as to why Kathryn felt she needed to end her life. This includes her sense of being overwhelmed by having to deal with so many agencies. However, at 15.6.2 it is suggested that her mental health impacted her ability to make rational decisions. Please could this be rephrased as it appears to be a judgement rather than a fact. At 15.7.3 it is noted that 'Children's Social Care have stated that they were aware that Kathryn was concerned about losing the care of Nyota, but they had reassured her on several occasions. Kathryn had also reported that she felt reassured by what professionals had told her.' The extent to which this reassurance reflected the reality of the situation warrants careful consideration.
11	Conclusions	No amendments required.
12	Lessons learnt and recommendations	The recommendations are closely linked to lessons learned. At learning point 1 the recommendation could incorporate the need for banks to be clearer about communicating their support offer to victim-survivors of domestic abuse and how to access specialist teams which exist.
13	Timescales	The review was unable to be completed in the six-month time frame due to:

		- Initial scoping inquiries (a large amount of information that was held by agencies and this impacted negatively on the completion of IMRs) and appointing a suitable Chair. - The need to contact organisations outside of the North Somerset area. Obtaining information from these organisations proved difficult despite repeated efforts by the CSP.
14	Involvement of family / friends / community	No amendments required
16	DHR contributors	No amendments required
17	DHR Panel	No amendments required
18	DHR Author	No amendments required
19	Parallel Reviews	The death of Kathryn was referred to HM Coroner's office, an inquest is yet to be held with regards to Kathryn, and a date had not been set for this when the report was submitted. Please ensure the report is updated to include the outcome of the inquest.
20	Dissemination	It is noted that the family are aware that the final overview report will be published. There is no reference to checking in with the family about key dates to avoid for publication or how the family will be supported if report publication leads to (renewed) media interest. This should be added.
21	Action Plan	Action planning: some actions identified lack clear timeframes which should be added.
22	Has there been a request to withhold publication? *If Yes, include the reason for the request. Is it proportionate and appropriate?*	No requests to withhold publication.

23	Any other comments	Refuge safety issue: A refuge failed to respond to an IMR request and advised Kathryn to turn on her phone, contradicting police advice and potentially exposing her and other residents to risk via IT surveillance.