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Lisa Jones
Safeguarding Adults Board Manager
Telford & Wrekin Safeguarding Partnership
11 Longbow Close,
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24th February 2026

Dear Lisa,

Thank you for submitting the Domestic Homicide Review (DHR) report (Margaret) for Telford & Wrekin Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 14th January 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	Margaret
COMMUNITY SAFETY PARTNERSHIP	Telford & Wrekin
DATE REVIEWED BY QA BOARD	14th January 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• There is a moving tribute to Margaret by her daughter. • The Chair engaged extensively and sensitively with Margaret's family, friends and work colleagues. Margaret's husband and daughter contributed to the review, as did her best friend with whom she had a long-standing and close relationship and colleagues from the care home where she worked. This demonstrates tenacity from the Chair. • A Mental Health Homicide Review was commissioned and has run concurrently with the DHR. The learning from this has been shared with DHR panel and family which was helpful. • It is positive to see that relevant research has been included. • The analysis section was noted as being excellent.
FEEDBACK FOR FUTURE DHRs	

	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	The equality and diversity section is currently brief and does not provide any analysis of intersectionality. Please review this accordingly.
8	Background Information	No amendments required.
9	Combined Chronology	No amendments required.
10	Overview	No amendments required.
11	Analysis	No amendments required.
12	Conclusions	No amendments required.
13	Lessons learnt and recommendations	No amendments required.
14	Timescales	No amendments required.
15	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	No amendments required.
20	Dissemination	The dissemination section does not currently specify who the DHR reports will be shared with. Please include the following: • Margaret's family • The local Police and Crime Commissioner • The Domestic Abuse Commissioner

		• Relevant local partnership organisations
21	Action Plan	Overall, the action plan is comprehensive in structure and scope. The plan references monthly audits, direct observations, and embedding risk assessments into reports, which promotes accountability. It does not currently explain how the effectiveness of these audits will be monitored or how improved outcomes will be demonstrated. Please clarify this where possible.
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	• This review should be considered for a case study to highlight how Margaret's voice and the family's lived experience of fear, coercion, threats, substance misuse, non-compliance with treatment and manipulative behaviour were largely absent from professional decision-making, and their normalisation of this behaviour was not challenged. The failure to complete domestic abuse risk assessments, involve the family meaningfully, or triangulate information allowed services to rely almost entirely on Jack's self-reporting, despite clear indicators of escalating risk. • There are two blank pages (33 and 34) immediately before the analysis section of the Overview Report. These should be removed. • A proofread is recommended as some grammatical errors and misspellings remain.