

Rose Parker
Head of Commissioning – Safer Communities
Community Safety and Resilience
Resident and Enabling Services
London Borough of Lambeth
London
SW2 9QQ

25th November 2025

Dear Rose,

Thank you for submitting the Domestic Homicide Review (DHR) report (Isabella) for Lambeth 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	Isabella
COMMUNITY SAFETY PARTNERSHIP	Lambeth
DATE REVIEWED BY QA BOARD	5 th November 2025
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• The DHR is well-structured, thoughtfully considered, and sensitive to the victim and her family. • The excellent use of specialist agencies enriched the review with deeper insights and amplified the voices of both the victim and perpetrator. Commissioning Wilson Hinds Consulting Limited for expertise on the experiences of women of Black African or Caribbean heritage demonstrated careful consideration and highlighted systemic barriers faced by marginalised communities. • There was consistent and commendable engagement with the victim's family and friends throughout the lengthy review process, ensuring they were kept informed, supported, and involved. • The section "Through the Eyes of the Victim" provided a profound understanding of the victim's life journey, trauma, decision-making, and emotional well-being. This was commended as particularly good practice. • There is strong equality and diversity analysis approached through an intersectional lens, exploring characteristics such as ethnicity, disability, and sex. • Learning is translated into focused, actionable recommendations that extend beyond individual agencies. • It was good to see early action was taken around taking on the lessons learned despite the delay. • It was helpful to see consideration of previous local DHRs in the analysis.
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	Please clarify whether family members contributed to the development of the Terms of Reference.
6	Equality and Diversity	Age could be considered for Isabella within this section as she was 24 when she met Martin and only 26 when she met Luke. Please consider including further analysis on this.
7	Background Information	No amendments required.
8	Combined Chronology	No amendments required.
9	Overview	No amendments required.
10	Analysis	- At section 5.12, the bullets reflecting examples of physical abuse veer into other forms of abuse. It would be helpful to move them to the relevant section i.e. verbal abuse, economic abuse. - It would be helpful to present more detail about the debates around 'cycles' of violence rather than reiterate the assertion made by GP Practice at section 5.314. - At section 5.315, good practice is cited about multiple reminders sent to Luke. It would be helpful to understand what these looked like. If they were letters, for example, he may not have received them. Please clarify this. - At section 5.398, the analysis highlights how the bed Luke threw out the window 'belonged' to him, but it was in Isabella's bedsit. It would be helpful to understand how this came about, especially given he lived in supported housing and had rent arrears. - At section 6.212, it would be good to mention the lack of security in the women-only block. This does not feature in the analysis and yet demonstrates how easily Luke accessed it. This is relevant to recommendation 9.
11	Conclusions	No amendments required.
12	Lessons learnt and recommendations	There is reference in the report about coming back to the point that people are allowed to pick up someone else's prescription, but this doesn't appear to happen. Please clarify this.

13	Timescales	No amendments required.
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	No amendments required.
20	Dissemination	Please indicate if consideration has been given to family support when it comes to publish the review and that consideration of key dates to avoid at publication has been undertaken. Please include Isabella's family on the dissemination list.
21	Action Plan	- Agencies were tasked to work on their internal actions and not wait for publication of the final report which has taken over four years. Whilst details are given about reporting structures and monitoring of recommendations, an action plan is not provided. Please ensure a populated action plan is included prior to publication. - A regional recommendation is made. Please outline how this will be monitored.
22	Has there been a request to withhold publication? <i>If Yes, include the reason for the request. Is it proportionate and appropriate?</i>	No requests for the DHR to be withheld.
23	Any other comments	- As set out above, this is a good DHR and the victim's life is well represented. - It also highlights previous lack of learning implementation from a DHR, which may be worth adding to the Action Plan.