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05 June 2026

Dear Amanda,

Thank you for submitting the Domestic Homicide Review (DHR) report (Elouise) for Norfolk Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 22nd April 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	Elouise
COMMUNITY SAFETY PARTNERSHIP	Norfolk
DATE REVIEWED BY QA BOARD	22 April 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• The extension of enquiries beyond the initial geographical area is notable good practice, reflecting thoroughness in developing a comprehensive understanding of the full context of Elouise's life. • The inclusion of a drawing by Elouise from when she was six years old is a thoughtful touch that immediately captures the reader's attention. • The review's length is warranted and evidences a comprehensive and diligent approach to accurately representing Elouise's lived experience. • The inclusion of an established evidence-based framework, such as Monckton-Smith's Eight Stages, is helpful in supporting structured and robust analysis within the review. • It is notable good practice that there was a mental health specialist input to the panel, strengthening professional oversight. • The review appropriately recognises Elouise as a child victim of domestic abuse in her own right, in line with the Domestic Abuse Act 2021, and is further strengthened by the inclusion of her own reflections, the addition of a report advisory notice by the Chair, and a clear, well-structured format despite the necessary length due to extensive agency involvement.
FEEDBACK FOR FUTURE DHRs	• For future reviews, a more concise and focused set of Terms of Reference would strengthen coherence and impact. • For future reviews, maintaining consistent, timely engagement with families and clearly evidencing how any barriers were addressed will further strengthen practice.

	• Equality and diversity sections should clearly evidence how protected characteristics and lived experiences shaped both risk and agency responses, with a consistent distinction between fact, analysis, and interpretation.

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
1	**Title Page**	No amendments required.
2	**Contents Page**	Please include dissemination section in list.
3	**Pen Portrait**	The report would benefit from a pen portrait. Please consider including one.
4	**Condolences**	No amendments required.
5	**Confidentiality and Anonymity**	No amendments required.
6	**Terms of Reference**	No amendments required
7	**Equality and Diversity**	To strengthen this section, please explicitly set out consideration of all protected characteristics, clearly distinguishing those not applicable and why.
8	**Background Information**	• The section would benefit from clearer distinction between evidenced fact (e.g. agency records) and family recollection or professional interpretation, as at times these are presented interchangeably. • There are opportunities to more explicitly draw out missed opportunities for intervention, particularly where early referrals (e.g. 2014 CSC referral, family concerns, police involvement) did not result in sustained safeguarding action. Please consider including.
9	**Combined Chronology**	• Individually, the below incidents are recorded; however, the chronology would be strengthened by explicitly identifying that the pattern reflects escalating harm, increasing vulnerability of the children, and a deteriorating safeguarding context. When considered cumulatively, these incidents indicate a clear escalation in risk and harm, which is not explicitly drawn out within the chronology.

		• For example, between June and October 2021, the chronology records multiple incidents that, when viewed cumulatively, demonstrate clear escalation in risk:
		  ○ Elouise expressing suicidal ideation linked to abuse by her father
		  ○ Repeated ED attendances for both Elouise and Clive, including self-harm and mental health crises
		  ○ Elouise being placed in a caring role for her father, alongside exposure to coercive and controlling behaviour
		  ○ Self-harm by Clive in the presence of the children, including sending images
		  ○ Escalating police involvement and arrests involving both Clive and Elouise
		  ○ Evidence of housing instability, financial hardship, and neglect indicators
		  ○ Missed safeguarding opportunities, including no referrals following ED attendances and threshold decisions not revisited

10	**Overview**	No amendments required
11	**Analysis**	No amendments required
12	**Conclusions**	• The conclusion would benefit from reducing descriptive detail and focusing more explicitly on what this means for agency practice and missed opportunities for intervention. • Key findings particularly in relation to victim blaming, failure to recognise Elouise as a victim in her own right, limited professional curiosity, and gaps across child and adult systems are evident but would be strengthened by being clearly drawn together into a small number of overarching multi-agency findings.
13	**Lessons learnt and recommendations**	• The section would benefit from tighter drafting so that each lesson is clearly stated, directly evidenced from the review, and then linked to a corresponding recommendation. Some content currently reads as further analysis or contextual commentary rather than a concise statement of learning. • The recommendations would also be strengthened by being more specific, outcome-focused, and clearly measurable, as a number remain broad, training-led, or framed as developing tools or briefings without clearly stating what practice or system change is expected.

		• Please consider an additional recommendation for children social care addressing the requirement for anger management for Clive as part of the child protection plan as this is inappropriate for perpetrators of DA and controlling and coercive behaviour.
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**	The section would benefit from briefly clarifying how learning from these reviews informed the DHR findings, and providing clearer rationale regarding the initial decision that the Cambridge Community Service case did not meet the Serious Incident threshold and why this was revisited.
20	**Dissemination**	Please ensure the family are aware of publication date in case of press enquires
21	**Action Plan**	Measures of success are not clearly defined, and several actions lack clear endpoints or ownership. Stronger emphasis is needed on how learning will be embedded, evaluated, and sustained, with clear indicators of impact and partnership oversight. Please amend accordingly.
22	**Has there been a request to withhold publication?** ***If Yes, include the reason for the request. Is it***	No requests to withhold publication.

	proportionate and appropriate?	
23	**Any other comments**	• The review does not clearly state the cause of death. While it confirms that Elouise sustained serious injuries and was subsequently pronounced deceased, the absence of a clear description of how she died limits understanding of the nature and severity of the harm and weakens the analysis of risk and escalation. • A more concise and focused executive summary would significantly improve readability, sharpen the learning, and better meet the purpose. • The chair effectively challenges instances within the IMRs where language may imply victim-blaming. This is an important aspect of quality assurance, and it is commendable that the chair highlights the importance of accurate and respectful language. It is particularly disappointing to read that some of the victim blaming language was used in MARAC. • There is a typo in recommendation 13, it should read ‘had’. • This review details the tragic circumstances of a family entirely controlled by Clive and identifies several missed opportunities for recognising and responding to abuse. The CSP is encouraged to share the critical learning emerging from this review through an appropriate learning event.