DHR 2014 – Mary

Independent Chair's response to Home Office Quality Assurance Panel comments

Quality Assurance Panel comments	Action to be taken
Omission not to inform the family of the DHR at the start of the process.	The rationale for this is included on page 9 of the Overview Report.
It would aid understanding if the medical procedure mentioned a number of times in the report was more explicitly defined;	For reasons of patient confidentiality and out of respect for the deceased and her family, detailed information about Mary's medical conditions, symptoms, and treatments is not included in the Overview Report.
References to various medications, such as Benzodiazepine, and medical terms, such as "asymptomatic", which could usefully be explained in footnotes to assist non-medical readers;	A footnote has been included
It would be helpful if the report could give details of the chair and set out his independence;	This has been included
Equality and diversity issues have not been considered in the review	At the time of writing the Report, the relevant Home Office guidance was followed. This guidance did not include a requirement to incorporate a section on Equality or Diversity. The Home Office issued new guidance following the submission of the Report to the Home Office Quality Assurance Panel. Therefore this section will not be included
There is no voluntary sector representation on the review panel	This point will be relayed to the Warwickshire Domestic Homicide Review Sub-Group to consider as best practice for future Domestic Homicide Reviews conducted within the county

Quality Assurance Panel comments	Action to be taken
It would be helpful if the report could explain whether or not a mental health review was conducted given the victim had been seen by mental health practitioners during her hospital admissions in the six months prior to the homicide	This was a Serious Incident Requiring Investigation, registered with Coventry and Warwickshire Partnership Trust commissioners. It was not subject to further Root Cause Analysis as the case was reviewed through the DHR process. This formed the investigation of this case, with the Trust's contribution to that process via the undertaking of an IMR and chronology.
The action plan requires updating and some of the recommendations for the local partnership have no entries in the "action to take" column;	The action plan has been updated with the relevant information
Enhance anonymity by removing the precise date of death given in the introduction on page 10.	This has been removed