Executive Summary
of the Domestic Homicide Review

In respect of the death of Baksho[1]
In January 2020

Report produced for Dudley Safe and Sound[2] by
Paula Harding
Independent Chair and Author
January 2023

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[1] Pseudonym

[2] Dudley Safe and Sound is the name for Dudley Community Safety Partnership

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1. The homicide

1.1.1 This domestic homicide review concerns the homicide of Baksho (pseudonym), an 82-year-old woman, who was killed by her husband, Kesar (pseudonym) in January 2020. Although the death was not initially considered to be suspicious, a post-mortem revealed that Baksho had died from a sustained and violent attack and her husband was arrested on suspicion of murdering her.

1.1.2 Following the homicide, Kesar experienced a rapid deterioration in his health, was diagnosed with dementia and needed 24-hour care. He was found to be mentally unfit to stand trial and was convicted of her manslaughter in his absence. He was sentenced to a Supervision Order for two years and for him to reside at home, or at a place directed by the supervising social worker, where his 24-hour care would continue.

2. Summary of Chronology

2.1. Both Baksho and Kesar were Panjabi and of Sikh faith and had been married for 63 years. They had 4 grown-up children and 14 grandchildren and lived in a prosperous home which they shared with one of their children and his family. Baksho's family were prominent health providers in the region.

2.2. Neither Baksho nor her husband had contact with agencies beyond health and, for a short period, social services. Baksho had hypertension and glaucoma. Kesar also had hypertension and was receiving treatment for cancer. However, practitioners reported that they did not notice any significant change in his behaviour over the duration of his treatments.

2.3. In early 2018, Baksho underwent surgery for a fractured hip. The doctor considered that the fall was likely to have been accidental and that previous surgery to replace both knees may have contributed.

2.4. Whilst it was recorded that a Punjabi interpreter would be needed, one was not arranged throughout the month that Baksho was in hospital and family members were relied upon to interpret for them when they were present. Prior to discharge, Baksho appeared confused. The doctor considered that the confusion was due to a common reaction to medication, although the language barrier hindered diagnosis.

2.5. Baksho was discharged home with a package of care involving four calls per day from carers within the local authority's Urgent Care Team. Baksho went to stay with another of her grown up children out of the area for a short period and thereafter her care was transferred to a private care provider.

2.6. Thereafter, Baksho did not attend three hospital appointments which had been scheduled to review her progress post-surgery and, other than ophthalmology assessments for glaucoma, Baksho had no other contact with agencies before she was killed in January 2020.

3. Key Findings

3.1. Communication

3.1.1 Baksho spoke Punjabi and had little command of English. She was usually accompanied by family members who were used by practitioners across health and social care to interpret for them, including during a month-long stay in hospital.

3.1.2 Whilst it is understandable that practitioners sought to involve family members in Baksho's care, the absence of an interpreter, and the lack of recording of whether she was seen alone or accompanied had implications for Baksho. There were implications for her personalised care and treatment and missed opportunities to make safeguarding enquiries concerning indicators of domestic abuse or explore further the confusion that she appeared to be experiencing.

Learning point: the use of interpreters & the need to see people on their own for at least part of the assessment

Interpreters should always be used for assessments, discharge and care planning where a patient's first language is not English. This is because a number of problems can arise from the use of family or community members, friends, and children rather than professional interpreters.

- They may not understand or interpret everything that is being said.
- They may insert their own opinions or impose their own judgment as they interpret.
- They may inadvertently or deliberately obscure the voice, wishes and feelings of the individual and prevent person-centred and person-led care and treatment.

From a domestic abuse and safeguarding perspective,

- The individual may not be able to disclose abuse, particularly if it is perpetrated by an interpreter or family member
- The family member may share, or be capable of sharing, information that has been heard, with the wider family or community.
- Individuals should always been seen on their own, wherever possible, for at least a part of the assessment

3.2. Recording who is accompanying an individual

3.2.1 Although Adult Social Care recorded that they were unable to speak with Baksho on her own, there were few records across health and social care agencies detailing which members of the family were present.

Learning Point: Accompanying Adults
Practitioners should record who accompanies an adult in order to demonstrate familial support networks and which persons are involved in a caring role. It could also identify those who may pose a risk to an individual and signal the need to see someone on their own.

3.3. Selective Enquiry

3.3.1 In the post-operative review, the doctor made enquiries about the cause of her fall and received an explanation which was consistent with Baksho's health and age, and which did not give cause for suspicion about intentional harm. This appeared to be a missed opportunity to directly ask her about domestic abuse, either then, if it could be done safely, or at a later time when she was seen alone and with an interpreter present.

Learning Point: Selective Enquiry in Safe Environments
Healthcare professionals have a unique window of opportunity to respond to victims of domestic abuse.
All front-line health and social care staff should be equipped with the knowledge and skills they need to enquire about domestic abuse safely, sensitively and supportively through an explorative conversation.

3.3.2 The review recognised that in the intervening time, much work had taken place in local health settings to develop a whole health response to domestic abuse, which was seen as good practice, including:

- Hospital domestic abuse policies and training
- co-located Independent Domestic Violence Advisors (IDVAs) in the hospital in a partnership with Black Country Women's Aid
- the roll-out of the Identification and Referral to Improve Safety (IRIS) programme across primary care

3.4. Discharge from Hospital and Domiciliary Care

3.4.1 There was good communication with the family in the discharge planning process, but the process would have benefited from a subsequent review at home and Adult Social Care have since introduced a system to do this within 72 hours of discharge. Thereafter no concerns were noted by the visiting domiciliary carers, although it was not recorded whether the carers were trained in identifying domestic abuse.

Learning Point: Training Domiciliary Carers in Domestic Abuse.
Few practitioners have the opportunity to observe day-to-day life within an individual's home. By virtue of their discreet presence in the home environment, domiciliary carers have a unique role in identifying indicators of domestic abuse where they are present.

3.5. Follow-Up of 'Did Not Attends'

3.5.1 Baksho did not attend any of the three appointments at hospital for follow-up to her surgery and the GP Practice did not receive any of the notifications to this effect sent by the hospital on each occasion. There was therefore no follow-up undertaken.

3.6. Falls Prevention and Domestic Abuse

3.6.1 Although a falls assessment was undertaken, it was not known whether Baksho's earlier fall was indeed accidental as opportunities did not appear to have been sought to ask Baksho safely about the potential for abuse.

Learning Point: Domestic Abuse Disguised as a Propensity to Falls
Domestic abuse in older populations can easily be disguised as frailty and a propensity to falls. Practitioners should be engaging victims of falls in safe, sensitive, exploratory conversations and enquiry into domestic abuse.

3.7. Equality and Diversity

3.7.1 Practitioners appeared confident in their reliance upon Baksho's family to interpret for her and the panel reflected upon cultural assumptions that abound about the expectation that the family in Sikh communities will take on the caring role. The effect of these decisions was to provide a barrier to Baksho, as an older Sikh woman who spoke little English, to disclosing domestic abuse and seeking help, had she wanted to.

Learning Point: Black and Minoritised Women may experience additional barriers to identifying, disclosing, seeking help or reporting abuse including:

- A mistrust of agencies
- A fear of racism and racial stereotyping
- Language barriers
- Fear of rejection by family and wider community
- Intersecting identities will compound the barriers that they face

3.7.2 The panel reflected that unconscious bias concerning older people's experience of domestic abuse was also commonplace and abuse amongst older generations often

minimised or ignored. This may also have affected the response of practitioners in the contact that they had with Baksho.

3.7.3 The review heard how CHADD, the local domestic abuse service, was already providing specialist domestic abuse refuge provision and dedicated Independent Domestic Violence Advisors for older people. In addition, Domestic Abuse Local Partnership Board had been raising awareness amongst the public and partner agencies about the needs of older people experiencing domestic abuse and had identified within its training needs analysis, the need to further raise awareness and responses to domestic abuse in older people's lives. Work was also ongoing regionally to explore effective risk assessment of domestic abuse for older people. In these ways, Dudley could be seen to have placed the needs of older people experiencing domestic abuse firmly in place in its local response to domestic abuse.

Learning Point: Domestic Abuse and Older People. A 'generational invisibility' and a 'generational silence.'

Practitioners need to be aware that domestic abuse occurs across the age span and that older people face additional barriers to understanding their experiences as domestic abuse and in accessing help including that:

- They are less likely to identify their experiences as domestic abuse
- They are less likely to have lived with abuse for prolonged periods before getting help
- They may lack awareness of support services and less likely to want to discuss personal matters with professionals
- They may face isolation and fear disrupting family dynamics
- They are more likely to suffer from health problems, reduced mobility or other disabilities which can exacerbate their vulnerability to harm
- If they have intersecting identities, this will compound the barriers that they face

Domestic Abuse Statutory Guidance (2021) emphasises the importance of supporting older people to make safe and informed choices when seeking help and directs agencies to consider the guidance: Transforming the Response to Domestic Abuse in Later Life [1] to improve their responses.

[1] Available at https://dewischoice.org.uk/wp-content/uploads/2021/12/Practitioner-guidance-document-English-epdf_compressed.pdf

4. Recommendations

4.1 Overview Recommendations

Recommendation 1: Use of Interpreters
Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that interpreting services are being consistently used with individuals who may be at risk of domestic abuse.

Recommendation 2: Accompanying Adults
Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that partner agencies are consistently recording who accompanies an adult is present during discussions and assessments

Recommendation 3: Selective Enquiry in Safe Environments
Dudley Safe and Sound to promote safe, targeted and selective enquiry into domestic abuse across front-line health and social services.

Dudley Domestic Abuse Local Partnership Board to seek assurance from front line health and social services that routine/ selective enquiry into domestic abuse is embedded into local policy and procedures, and routinely being undertaken, in keeping with the National Institute for Health and Care Excellence, Quality Standard QS 116

Recommendation 4: Training Domiciliary Carers in Domestic Abuse. Dudley Council to ensure that all front-line Adult Social Care staff, including carers, have been trained in identifying and responding to domestic abuse

Recommendation 5: Follow-Up of 'Did Not Attends'
Black Country Integrated Care Board and Dudley Group to review the communication pathway to ensure that all notifications concerning 'did not attend' issued by the hospital are being received and, where necessary, followed up by primary care.

Recommendation 6: Falls prevention and domestic abuse
Dudley Domestic Abuse Local Partnership Board to recommend to Dudley Falls Prevention Partnership that a domestic abuse focussed review of its policies and procedures is undertaken to ensure
(a) that routine enquiry on domestic abuse is systematically included in assessments pre and post discharge after there has been an injury from a fall when considering falls prevention advice with an individual and

(b) that public information signposts potential victims of domestic abuse to sources of help.
(c) that written awareness materials are also made available in the main community languages in the area.

Recommendation 7: Black and minoritised women
Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with agencies and the public that domestic abuse occurs across communities and seek assurance that partner agencies are working to effectively address the barriers that Black and minoritised women face, including challenging prejudice and stereotypes that restrict the options available to them.

Recommendation 8: Domestic abuse and older people
Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with the public that domestic abuse occurs across the age span and advertise the help that is available.

Once its toolkit[3] for working with older people is developed and implemented, Dudley Domestic Abuse Local Partnership Board should monitor the numbers of older people being referred into services and seek assurance that partner agencies are working to effectively address the barriers that older women face, including challenging prejudice and stereotypes that restrict the options available to them.

Recommendation 9: Private Care Providers
Dudley health and social care commissioners of domiciliary care to consider introducing contractual requirements that care providers have domestic abuse policies and provide training and support to their care workers in the identification and response to domestic abuse.

Recommendation 10: Private sector engagement with domestic homicide review (Local)
Dudley's health and social care commissioners to consider introducing contractual requirements that require contracted health and care services fully co-operate with domestic homicide and safeguarding reviews.

[3] The toolkit is part of the wider training package

Recommendation 11: Private sector engagement with domestic homicide review (National)

Dudley Safe and Sound to consider making recommendations to government to extend the persons and bodies responsible for engagement with domestic homicide reviews, under section 9(4) of the Domestic Violence Crime and Victims Act 2004, to include private sector companies engaged in the provision of health and social care services.

4.2 Individual Recommendations

Dudley Council Adult Social Care

- 72hr post discharge review to be carried out for all urgent care referrals, to ensure any changes in need or identification of aids and adaptations are confirmed in a timely manner.
- Discharge team to review discharge documentation prior to discharge.

Black Country Integrated Care Board

- Provide IRIS training for the practice
- Facilitate safeguarding training for all Practice Nursing Staff in Dudley.
- Introduce a domestic abuse policy in the GP Practice concerned

Dudley Group NHS Foundation Trust

- Raise awareness and accessibility around use of interpreters
- Raise awareness of staff that they must document who else is present, including friends, family, interpreter at every contact as part of their record keeping
- Continue to raise awareness and highlight the need for staff to obtain the wishes and feeling of patients in their care and discharge planning arrangements

Appendix: The Review Process

i. Summary

The decision to undertake a domestic homicide review was made by the Chair of Dudley Safe and Sound in consultation with partner agencies, on 30.09.2020 and the Home Office was notified of the decision on the same day. An independent chair and review panel were appointed, and the review was managed in accordance with the relevant statutory guidance.

The review panel members are listed below and included representation from Black Country Women's Aid, who deliver domestic abuse services in the area. They provided particular expertise on gender, domestic abuse, race and the broader 'victim's perspective' to the panel. The panel members were all independent of the particular case.

The process was delayed thereafter, whilst waiting for criminal proceedings to conclude. Terms of reference were drawn up and incorporated key lines of enquiry as featured below Agencies participating in this review are featured below as well as those who had no contact. The review panel went on to meet on three occasions.

Family members were invited to engage with the review at various times but were deemed to have declined. They were provided with details of specialist agencies for support. The perpetrator was not considered by clinicians to have mental capacity to be able to engage with the review.

The Overview Report was endorsed by Dudley Safe and Sound in 30.01.23 before being submitted to the Home Office for approval.

ii. Review Panel Members

Designation	Organisation
Independent Chair	-
Head of Assessment & Independence	Dudley Council Adult Social Care
Designated Nurse Safeguarding Children	Black Country Integrated Care Board
Detective Sergeant	West Midlands Police
Community Safety Officer	Dudley Council Community Safety
Regional Head of Domestic Abuse Services	Black Country Women's Aid
Head of Safeguarding	Dudley Group NHS Foundation Trust

iii. Independence of the Chair

Paula Harding was the Independent Chair and Overview Author for this review.

Beyond undertaking domestic homicide and safeguarding adult reviews, Paula Harding had not been employed by any agency in Dudley.

iv. Key Lines of Enquiry

The review sought to address both the ‘circumstances of a particular concern’ set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- **What opportunities did agencies have in identifying and responding to indicators of domestic abuse during their contact with Baksho and how effective were these responses?**
  To consider:
  - *Providing a pen picture of Baksho as known by agencies at the time of contact*
  - *Responses to any indicators of domestic abuse as detailed in NICE Quality Standard QS116 Domestic Violence and Abuse, available at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse*
  - *Whether routine/direct/selective enquiry on domestic abuse was undertaken and rationale for decision making*
  - *What barriers to engagement did agencies face and how did they seek to overcome these barriers, including isolation and language needs*
  - *How did agencies recognise and respond to issues of equality and diversity for Baksho? Was there any evidence of unconscious bias in the assessments, decisions or services delivered?*

- **Additional Questions for Dudley Group NHS Foundation Trust**
  - *Reasons for length of inpatient stay*
  - *What opportunities for meaningful engagement and disclosure of abuse during this time*
  - *Observations on visiting*
  - *Whether there were indicators of confusion and how responded to*
  - *Whether any actions were, or could have been, taken to explore the patient’s non-attendance at their follow-up appointment*

- **Additional Questions for Adult Social Care**
  - *Conclusions of discharge assessment undertaken*
  - *Reasons and expectations of referral to Urgent Care*
  - *How did the service identify and respond, individually or collectively, to Baksho’s post-operative rehabilitation needs?*
  - *What were the nature of discharge assessments?*
  - *Should there have been a multi-agency discharge planning meeting in view of the delays in discharge*
  - *Whether carers were identified and support offered*

- **What can be established from informal networks (family, friends, community) regarding any domestic abuse in the household? How can the circumstances contribute to our collective understanding of domestic abuse?**
- **What lessons can be learnt to prevent harm in the future?**

v.Agency Involvement in the Review

Individual Management Reviews and chronologies were provided by:

- Dudley Council Adult Social Care
- Dudley Group NHS Foundation Trust
- Black Country Integrated Care Board (ICB) – Dudley Place[4].

Limited Information was provided by:

- Bewdley Social Care
- Tipton Home Care

The following agencies were contacted but confirmed that neither Baksho nor her husband were known to them, or their involvement was not relevant to the review:

- Black Country Women's Aid (regional domestic abuse service)
- Black Country Healthcare NHS Foundation Trust
- CHADD (local domestic abuse service)
- Dudley Council Children's and Education Services
- Dudley and Walsall NHS Partnership Trust
- Probation Service
- West Midlands Ambulance Service
- West Midlands Police

[4] Formerly Black Country and West Birmingham Clinical Commissioning Group (CCG) – Dudley Place

Domestic Homicide Review

under section 9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of Baksho [1]

In January 2020

Report produced for Dudley Safe and Sound[2] by
Paula Harding
Independent Chair and Author

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[1] Pseudonym
[2] Dudley Safe and Sound is the name for Dudley Community Safety Partnership

ACRONYMS

AAFDA: Advocacy After Fatal Domestic Abuse
CSP: Community Safety Partnership
CCG: Clinical Commissioning Group
DHR: Domestic Homicide Review
GP: General Practitioner
ICB: Integrated Care Board
IDVA: Independent Domestic Violence Advisor
IMR: Individual Management Review – reports submitted to review by agencies
IRIS: Identification and Referral to Improve Safety - a general practice-based domestic violence and abuse training support and referral programme
SMART: Specific, Measurable, Achievable, Relevant, and Time-bound

GLOSSARY

Making Every Contact Count is an approach recommended by NHS England and Public Health England which maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors to take place.

Routine Enquiry in domestic abuse means all individuals are asked about domestic abuse and is an expectation of maternity, mental health and sexual health services .

Selective enquiry in domestic abuse occurs when individuals are only asked when they present with possible indicators of abuse. In health and social care settings, these indicators feature in the National Institute for Health and Care Excellence Quality Standard QS116 (NICE,2016)

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ACKNOWLEDGEMENTS

Members of the review panel offer their deepest sympathy to all who have been affected by the death of the victim.

The Chair would like to thank the panel and contributors for their commitment to the review and to improving services for victims of domestic abuse

PREFACE

The victim's family will be invited to provide a personal statement about the victim, their loss and the impact of her death, to accompany the review before publication.

1. INTRODUCTION

1.1. The homicide

1.1.1 This domestic homicide review concerns the homicide of Baksho (pseudonym), an 82-year-old woman who was the mother of 4 grown-up children and 14 grandchildren. Baksho was killed by her husband, Kesar (pseudonym), also aged 82 at the time of the homicide, and with whom she had been married for 63 years.

1.1.2 Her husband was found to be mentally unfit to stand trial and was convicted in his absence of her manslaughter.

1.2. Aim and purpose of a domestic homicide review

1.2.1. Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom she was related or with whom she was or had been in an intimate personal relationship or (b) member of the same household as herself; with a view to identifying the lessons to be learnt from the death.

1.2.2. Statutory guidance stipulates that the purpose of a DHR is to:

(a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

(b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

(c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

(d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated

multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

(e) contribute to a better understanding of the nature of domestic violence and abuse; and

(f) highlight good practice." (Home Office, 2016:6)

1.1.3 In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1.4 The review examined agency responses and support given to the victim in the period prior to her homicide. In addition to agency involvement, the review examined the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed in the community and whether there were any known barriers to accessing support. By taking a holistic approach, the review sought to identify relevant solutions to make the future safer.

1.3. Timescales

1.3.1. Dudley Safe and Sound, the local Community Safety Partnership, was notified of the death by West Midlands Police in February 2020. The decision to undertake a review was made by the Chair of the Partnership, in consultation with local agencies, and after further information was sought from the police investigation, in September 2020. The Home Office was notified of the decision in writing on the same day. The Home Office had been updated of the delays in the decision-making process.

1.3.2. The report of the review was endorsed by Dudley Safe and Sound in January 2023 before being submitted to the Home Office Quality Assurance Panel in April 2023. In November 2023, Dudley received a letter from the Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.3.3. Home Office guidance states that the review should be completed within six months of the initial decision to establish one. In this case, the review was delayed until criminal proceedings and sentencing reached a conclusion in April 2022. Criminal proceedings had themselves been delayed whilst Kesar's mental health was being considered. Thereafter the review encountered delays whilst trying to secure individual

management reviews from the private care providers involved in the victim's care. This issue forms the basis of one of the recommendations which follows in this report.

1.4. Confidentiality and anonymisation

1.4.1. This review has been anonymised in accordance with statutory guidance and only the Independent Chair and review panel members are named.

1.4.2. During the course of this review, the details have remained confidential, available only to participating professionals and their direct line management. This report has sought to extract sufficient detail from the victim's narrative for the lessons and recommendations to be understood, whilst balancing this need for confidentiality.

1.4.3. In order to protect the identities of the victim and her family, and in keeping with Home Office guidance, the use of pseudonyms was considered, and specialist advice was sought regarding culturally specific names which were commonly used in the generation of the individuals concerned.

1.5. Definition

1.5.1. The Domestic Abuse Act 2021 introduced a legal definition of domestic abusive behaviour as consisting of a single incident or course of conduct between two people who are personally connected, each aged 16 or over, and involving any of the following:

(a) physical or sexual abuse
(b) violent or threatening behaviour
(c) controlling or coercive behaviour
(d) economic abuse
(e) psychological, emotional or other abuse (s1: Domestic Abuse Act 2021)[3]

1.5.2. What constitutes controlling or coercive behaviour is outlined in guidance issued by the Government under section 77 of the Serious Crime Act 2015.

"Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

[3] https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."[4]

1.6. Methodology and Family Engagement

1.6.1. The review followed the methodology required by the *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (HM Government, 2016). All local agencies were notified of the death and were promptly asked to examine their records to establish if they had been approached by, or provided any services to, the couple and to secure records if there had been any involvement.

1.6.2. Arrangements were made to appoint the Independent Domestic Homicide Review Chair and Author and agree the make-up of the multi-agency review panel. Baksho's family were visited by police officers and notified of the domestic homicide review. They were invited to engage with the review and to meet the Independent Chair and consider the terms of reference. They were also provided with leaflets from the specialist advocacy support services of AAFDA and Victim Support Homicide Service. However, they declined to engage with the review. The family were notified when the review was reaching its conclusion and provided the opportunity to meet with the Chair and consider the draft report at that time, but no response was received and they were deemed to have declined to be involved.

1.6.3. The panel initially met in advance of the conclusion of criminal proceedings in order to set the terms of reference and identify any immediate concerns for agencies' practice. Once criminal proceedings had concluded, the panel went on to meet a further two times.

1.6.4. There was little agency contact with either Baksho or her husband. However, those agencies that were involved were asked to provide a chronology of their contacts and analysis of their involvement. Panel members were able to discuss the progress of the review reports and request further clarification and additional material, where needed. All panel meetings were minuted and all actions agreed for the panel have been completed.

1.6.5. The Independent Chair authored the Overview Report, and each draft was discussed and endorsed by the review panel before submission to the Community Safety

[4] Home Office, (2020) Domestic Abuse Draft Statutory Guidance Framework. https://www.gov.uk/government/publications/domestic-abuse-bill-2020-overarching-documents

Partnership. The draft Overview Report was endorsed by Dudley Safe and Sound prior to submission to the Home Office.

1.6.6. Family members will be notified before publication of the report, and engagement and support will be offered by the Partnership again at this time.

1.6.7. Consideration was given to engagement with Kesar, but clinical advice was sought concerning his health and mental capacity and it was considered that he would not be able to engage with the review.

1.7. Members of the Review Panel

1.7.1. Multi-agency membership of this review panel was determined by the Independent Chair and consisted of senior managers and/or designated professionals from the key statutory agencies. Panel members had not had any direct contact or management involvement with Baksho.

1.7.2. Black Country Women's Aid who deliver domestic abuse services in the area, provided particular expertise on domestic abuse in minoritised communities as well as the broader 'victim's perspective' to the panel.

1.7.3. The review panel members were:

Designation	Organisation
Independent Chair	-
Head of Assessment & Independence	Dudley Council Adult Social Care
Designated Nurse Safeguarding Children	Black Country Integrated Care Board- Dudley Place
Detective Sergeant	West Midlands Police
Community Safety Officer	Dudley Council Community Safety
Regional Head of Domestic Abuse Service	Black Country Women's Aid
Head of Safeguarding	Dudley Group NHS Foundation Trust

1.8. Independent Chair and Overview Author

1.8.1. The Independent Chair and Overview Author is Paula Harding. She has over thirty years' experience of working in domestic abuse and related services. Her senior local

authority and third sector experience has spanned working in refuge, advice and outreach services; management of front-line services; training and development; policy formation and strategic commissioning. She completed an M.A. (Birmingham) in Equalities and Social Policy in 1997, focusing on domestic violence and social welfare, and is a regular contributor to conferences, national consultations and academic research. She completed the OCR certificated training funded by the Home Office for *Independent Chairs of Domestic Homicide Reviews* in 2013. She has also completed the on-line training provided by the Home Office: *Conducting a Homicide Review*[5].

1.8.2. Paula Harding worked for a large metropolitan local authority in the region as the strategic lead for violence against women for more than a decade. Since leaving the statutory sector in 2016, Paula Harding has worked as an independent consultant, mainly engaged in chairing and authoring domestic homicide and safeguarding adult reviews. She has also worked with Women's Aid organisations to help improve their strategic planning and improve how they demonstrate outcomes from their work. Beyond undertaking domestic homicide and safeguarding adult reviews, Paula Harding had not been employed by any agency in Dudley.

1.9. Contributors to the Review

1.9.1. A total of 11 agencies were contacted to check for involvement with the parties concerned with this DHR. Of these, 5 had relevant contact and were asked to submit reports based upon the extent of their involvement. A narrative chronology was also prepared.

1.9.2. Individual agency reports and chronologies were provided by the following organisations:

- Dudley Council Adult Social Care
- Dudley Group NHS Foundation Trust
- Black Country Integrated Care Board (ICB) – Dudley Place[6].

1.9.3. These reports were written by authors who were independent of the case and were sufficiently comprehensive to enable the panel to analyse agency involvement and to

[5] Available at https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning
[6] Formerly Black Country and West Birmingham Clinical Commissioning Group (CCG) – Dudley Place

produce learning for the review. Where necessary further questions were sent to agencies and responses were received.

1.9.4. Despite requesting individual management reports, only limited information was provided by the two private care companies, Bewdley Social Care and Tipton Home Care, who were involved in Baksho's care during her rehabilitation from hospital, two years before her homicide. The issue of private company involvement in review will be considered further in the report.

1.9.5. The following agencies were contacted but confirmed that neither Baksho nor her husband were not known to them, or that their involvement was not relevant to the review:

- Black Country Women's Aid (regional domestic abuse service)
- Black Country Healthcare NHS Foundation Trust
- CHADD (local domestic abuse service)
- Dudley Council Children's and Education Services
- Dudley and Walsall NHS Partnership Trust
- Probation Service
- West Midlands Ambulance Service
- West Midlands Police

1.10. Scope and Key Lines of Enquiry

1.10.1. The review sought to address both the 'circumstances of a particular concern' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- **What opportunities did agencies have in identifying and responding to indicators of domestic abuse during their contact with Baksho and how effective were these responses?**

  To consider:

  - *Providing a pen picture of Baksho as known by agencies at the time of contact*

- *Responses to any indicators of domestic abuse as detailed in NICE Quality Standard QS116 Domestic Violence and Abuse, available at https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse*
- *Whether routine/direct/selective enquiry on domestic abuse was undertaken and rationale for decision making*
- *What barriers to engagement did agencies face and how did they seek to overcome these barriers, including isolation and language needs*
- *How did agencies recognise and respond to issues of equality and diversity for Baksho? Was there any evidence of unconscious bias in the assessments, decisions or services delivered?*

- **Additional Questions for Dudley Group NHS Foundation Trust**
  - *Reasons for length of inpatient stay*
  - *What opportunities for meaningful engagement and disclosure of abuse during this time*
  - *Observations on visiting*
  - *Whether there were indicators of confusion and how responded to*
  - *Whether any actions were, or could have been, taken to explore the patient's non-attendance at their follow-up appointment*

- **Additional Questions for Adult Social Care**
  - *Conclusions of discharge assessment undertaken*
  - *Reasons and expectations of referral to Urgent Care*
  - *How did the service identify and respond, individually or collectively, to Baksho's post-operative rehabilitation needs?*
  - *What were the nature of discharge assessments?*
  - *Should there have been a multi-agency discharge planning meeting in view of the delays in discharge*
  - *Whether carers were identified and support offered*

- **What can be established from informal networks (family, friends, community) regarding any domestic abuse in the household? How can the circumstances contribute to our collective understanding of domestic abuse?**
- **What lessons can be learnt to prevent harm in the future?**

1.11. Time Period

1.11.1. The panel agreed that the review should focus on events from February 2018 when Baksho was admitted to hospital, until her death in January 2020. Although the panel were open to any significant information which might have come to light during the review outside the set timeframe, none was revealed.

1.12. Equality and Diversity

1.12.1. The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010[7] as well as to wider matters of vulnerability for both Baksho and her husband.

1.12.2. The review considered that the sex of the individuals required particular attention. Domestic abuse and domestic homicide are, most commonly, gendered crimes (Stark, 2007). In the three years before Baksho was killed by her husband, 96% of perpetrators of domestic homicides in England and Wales were male (ONS, 2021). The significance of sex and violence against women should, therefore, always be considered within a domestic homicide review.

1.12.3. Both Baksho and her husband were Indian and of Sikh faith. The panel considered whether issues of race, ethnicity and faith may have impacted upon the identification of any abuse or provided barriers to seeking help.

1.12.4. Baksho was aged 82 when she was killed and it was determined that her age should also receive particular attention, not least because older women face considerable barriers which result in them being less likely than younger women to be engaging in

[7] The nine protected characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation

domestic abuse services (Bows, 2018). The term ‘older women’ shall be used to refer to women over 60 in keeping with the usual transition to older people’s services.

1.12.5. We will see that Kesar experienced a rapid deterioration in his mental health after the homicide. Indeed, deteriorating mental health is a common feature of domestic homicide and the complex inter-relationship between domestic abuse and mental health was considered with the understanding that mental ill health does not usually, in itself, cause or excuse domestic abuse, but can exacerbate or intensify abuse (Bates, 2021:54; Montique, 2019).

1.12.6. Baksho’s family were prominent health providers in the region. Therefore, the impact of the relative affluence of the family was considered in respect of the options that may have been available, or perceived to be available, to Baksho.

1.12.7. The Review Panel took an intersectional analysis approach to better understand the lived experiences of both Baksho and her husband. This means to think of each characteristic of an individual as inextricably linked with all the other characteristics in order to fully understand an individual’s journey and experience with local services and within their community.

1.13. Parallel Reviews

1.13.1. Beyond criminal proceedings, the review panel was not made aware of any parallel proceedings.

1.14. Dissemination

1.14.1. The following recipients will receive a copy of the completed report:

- The victim’s family
- Agencies participating in the review
- Agencies of Dudley Community Safety Partnership
- Dudley Safeguarding People Partnership
- West Midlands Police and Crime Commissioner
- The Domestic Abuse Commissioner for England and Wales

1.14.2. It is intended that the report will be published on the Dudley Community Safety Partnership website, subject to approval by the Home Office

2. BACKGROUND INFORMATION

2.1. The victim's family history

2.1.1. In order to protect the identity of the victim and the family, the following anonymized terms have been used throughout this report:

Pseudonym	Individual	Age at time of death
Baksho	Victim	82
Kesar/ the perpetrator	Husband and perpetrator of the homicide	82

2.1.2. Both Baksho and her husband were both born in India and of Sikh faith. They came to the UK together during the 1960s and thereafter became UK citizens. They had 4 grown-up children and 14 grandchildren and lived in a prosperous home which they shared with one of their children and his family. Baksho's family were prominent health providers in the region.

2.1.3. Neither Baksho nor her husband had contact with agencies beyond health and, for a short period, social services. Baksho had long term health conditions of hypertension and glaucoma and was seen annually for a review of her hypertension and medication. Kesar also suffered long-term health conditions of hypertension and prostate cancer for which he attended regular reviews and treatment. He was registered at the same GP Practice as his wife and, although the Practice Nurses came to know Kesar reasonably well, they did not notice any significant change in his behaviour over the duration of his treatments.

2.2. The homicide

2.2.1. On a date in January 2020 (date redacted) West Midlands Ambulance Service received a 999 call from Baksho's son reporting the discovery of his deceased mother in the bedroom at the address. Although the death did not initially appear suspicious to the attending paramedics, a post-mortem later revealed that Baksho had a fractured sternum, a broken arm, several broken ribs and her body was covered in bruises, indicating that she had died of a sustained and violent assault. A police investigation ensued, and the victim's husband was subsequently arrested on suspicion of murdering her. The Crown's case was that her husband had struck her repeatedly with a walking stick found at the property, which he denied.

2.2.2. Kesar had been considered mentally fit at the time of his arrest and charge for murder in February 2020. However, the trial was delayed until November 2020, due to arrangements to manage the Covid-19 pandemic which followed shortly after the homicide. During this time, his health deteriorated to such an extent that he was not deemed fit to stand trial and the indictment was amended to one of Manslaughter. He was diagnosed with dementia and required 24-hour care. As a result, a trial of facts went ahead in his absence in August 2021 and the jury concluded that Kesar was guilty of manslaughter.

2.2.3. Sentencing concluded in April 2022. The court had only three disposals available: a hospital order, a supervision order or an absolute discharge. Judge Mayo presiding determined that:

> "the pre-conditions of a Hospital Order are not made out: the defendant is not suffering from any mental disorder of a nature or degree which requires his detention in hospital for treatment. In a case as serious as this, I am not prepared to consider any form of discharge." (Judge Mayo's Sentencing Remarks. 19.04.2021.)

2.2.4. Kesar was therefore sentenced to a Supervision Order for two years and for him to reside at home, or at a place directed by the supervising social worker, where his 24-hour care would continue. He has since been placed in a nursing home where his supervision continues.

3. CHRONOLOGY

3.1. In early February 2018, Baksho was admitted to hospital having suffered a fractured hip. The attending doctor noted that she spoke Punjabi and that an interpreter was needed to be booked. Baksho underwent surgery that evening and was admitted to the ward where she stayed for the next four weeks.

3.2. A nursing admission document was completed on transfer to the ward, and it was documented that dementia screening questions were not asked because of the language barrier as Baksho spoke little English. However, there was no evidence of further assessment or whether an interpreter would be required. It was recorded that her son was with her and interpreted for his mother.

3.3. On the morning after surgery, a doctor took her history although it was not recorded whether she was seen alone or had a relative or interpreter present. A 'Patient Fall Prevention and Management' assessment was undertaken and as she was at risk of falls whilst an inpatient, hourly checks were made of her thereafter. It was noted that

Baksho had been rushing downstairs to answer the door and fell down the last three steps. She experienced left hip pain and was unable to weight bear. The doctor documented the impression that the fall was likely to be accidental and that previous surgery to replace both knees may have contributed.

3.4. Nine days later, Baksho's recovery was reviewed by the surgical team, and she was considered to be fit for discharge. However, one of the doctors noted on their ward rounds that Baksho appeared confused, and communication was hindered by the language barrier. Her son also recognised that his mother was confused and spoke with the doctor directly. The doctor stopped the prescription for an antihistamine that the patient had been prescribed for a rash on her back as this is known to cause drowsiness and confusion.

3.5. Thirteen days later, the Assistant Care Co-ordinator carried out an assessment for Baksho on the ward. Her son had requested being involved in all assessments and decisions over his mother's care which was agreed. The assessment identified the need for a package of care upon discharge involving four calls per day. The tasks to be performed included supporting Baksho with washing, dressing and meal preparation. No safeguarding concerns were identified within the assessment. A stair assessment was also recommended before discharge to ascertain whether Baksho was safe to travel up and downstairs at home. If not safe to use stairs, furniture and equipment was to be arranged for downstairs living. Thereafter the discharge was delayed slightly whilst arrangements for domiciliary care were made with the family.

3.6. In early March 2018, Baksho was discharged home and her care commenced with one carer attending four times per day as arranged, although lunch and tea calls were often cancelled by Baksho or members of her family.

3.7. Within the next week, Baksho moved to stay with another of her grown-up children which was out of the catchment area for the GP. As a result of being out of area, the district nurse would not attend to change her dressing. In situations where someone is convalescing with family members out of area, it would be expected to register temporarily with a local GP who would put a referral in to the relevant district nurses if needed. The family were keen to retain the same GP and it appears that a member of the family, who were all medically trained, changed her dressing.

3.8. Baksho's domiciliary care transferred from the Urgent Care Team to a private care provider, Tipton Home Care. However, the responsibility for assessments still lay with the Urgent Care Team who undertook a review at home with her husband and son present, one month later. Baksho advised that only morning calls were needed from carers and her son requested a level access shower to be installed. In view of the delays that this would involve, Baksho's son advised that they would be paying for

future care, equipment and support and a list of providers was given. Baksho did not attend her follow up outpatient appointments which was scheduled for that day and whilst the hospital advised that the GP was notified, the GP Practice had not record of receiving it. Their normal practice when receiving such notifications would be to contact the patient and ask them to contact the Practice.

3.9. One month later, the Urgent Care Team carried out a courtesy telephone call to review the current situation and enquire whether private arrangements for Baksho's care had been arranged. Her son confirmed that Bewdley Care had been arranged to support his mother and their first call was that day. Urgent Care's involvement then ended.

3.10. Thereafter, Baksho did not attend two hospital outpatient appointments on 17.8.18 and 1.2.19. These routine appointments were to review Baksho's progress and provide an opportunity for any problems or concerns to be identified. The GP had no record of her non-attendance on this occasion either.

3.11. During this time, Baksho's husband was being treated for cancer. However, other than ophthalmology assessments for glaucoma, Baksho had no other contact with agencies before she was killed in January 2020.

4. ANALYSIS

4.0 Baksho had little contact with agencies aside from this short period in hospital following surgery for a hip fracture and subsequent domiciliary care and equipment to aid her recovery at home. The review therefore examined this period in detail to ensure expected levels of practice were adhered to and to see whether there were opportunities to explore her safety at home.

4.1. Communication

4.1.1. Baksho spoke Punjabi and had little command of English. When she was admitted to hospital, her language needs were noted on three occasions. However, there was no evidence of an interpreter being offered or used throughout the four weeks that Baksho stayed in hospital and, aside from one occasion, it was not recorded whether family members were present or assisting with interpretation.

4.1.2. The Dudley Group NHS Foundation Trust has an Interpreting and Translation Policy which states that a patient whose first language is not English, they should be offered the use of an interpreter. Where the patient declines the use of an interpreter and specifies that they wish to use a family member or carer, then staff should document

this. However, there was no documentation in the medical or nursing notes that an interpreter has been offered or that Baksho had expressed a wish to use her family to interpret. It was therefore not possible to know if staff considered the use of an interpreter or offered this service or how this may have impacted upon her ability to make decisions about her own care and treatment.

4.1.3. Likewise, Adult Social Care, in assessing Baksho's care needs, routinely used her family to interpret for her and it was not recorded whether she had been given a choice in this regard or had the opportunity to talk with the care co-ordinator on her own and with an independent interpreter.

4.1.4. The GP Practice reflected that Baksho was always accompanied by a family member to the Practice. However, she was seen very infrequently, attending only for her annual blood pressure checks for her hypertension and, as there were no indicators of any concerns, the need for an interpreter was not identified. Had concerns been raised they advised the panel that they would use Language Line to converse with patients independently.

4.1.5. Whilst it is understandable that practitioners sought to involve family members in Baksho's care, the absence of an interpreter, and the lack of recording of whether she was seen alone or accompanied, had a number of implications for Baksho. There were implications for her personalised care and treatment and missed opportunities to make safeguarding enquiries concerning indicators of domestic abuse or explore further the confusion that she appeared to be experiencing.

4.1.6. Personalised care and treatment to support an individual's well-being involves being person-focussed and person-led. In this situation, well-being involves:

> *"personal dignity …, physical and mental health and emotional wellbeing, protection from abuse and neglect; control by the individual over day-to-day life (including over care and support provided and the way it is provided)…"* (Department of Health and Social Care, 2022:para 1.5).

4.1.7. It is hard to see how her well-being, safety or engagement in decision making about her care and treatment, could be assured when her voice was mediated by another. Moreover, in the absence of a safe environment for potential disclosure, the absence of an interpreter challenges the principle of Making Safeguarding Personal:

> *"Making Safeguarding Personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety."* (Department of Health and Social Care, 2022:para 14.15).

4.1.8. Although there were no safeguarding issues disclosed or evident at the time that Baksho was in hospital[8], taking the time to talk with Baksho safely and in her own language, ascertaining her views and feelings, would have provided an opportunity for disclosure. The Dudley Group noted that since Baksho's admission, staff now have easier access to interpreters via telephone and Apps (software applications) and that their use has been promoted across the Trust with good effect.

4.1.9. The issue of the lack of use of interpreters has also featured in a recent domestic homicide review covering a similar period and, as a result, Dudley Safe and Sound and Dudley Safeguarding People Partnership issued joint guidance to agencies in the area on this matter[9].

Learning Point: the use of interpreters & the need to see people on their own for at least part of the assessment

Interpreters should always be used for assessments, discharge and care planning where a patient's first language is not English.

This is because a number of problems can arise from the use of family or community members, friends, and children rather than professional interpreters.

- They may not understand or interpret everything that is being said.
- They may insert their own opinions or impose their own judgment as they interpret.
- They may inadvertently or deliberately obscure the voice, wishes and feelings of the individual and prevent person-centred and person-led care and treatment.

From a domestic abuse and safeguarding perspective,

- The individual may not be able to disclose abuse, particularly if it is perpetrated by an interpreter or family member
- The family member may share, or be capable of sharing, information that has been heard, with the wider family or community.
- Individuals should always been seen on their own, wherever possible, for at least a part of the assessment

[8] See later consideration of the cause of her fall as an indicator of potential domestic abuse.
[9] Available at https://www.dudleysafeandsound.org/domesticabuse and https://safeguarding.dudley.gov.uk/safeguarding/adults/work-with-adults/

Recommendation 1: Use of Interpreters

Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that interpreting services are being consistently used with individuals who may be at risk of domestic abuse.

4.2. Recording who is accompanying an individual

4.2.1. Although, Adult Social Care recorded that they were unable to speak with Baksho or her husband without the children present, there were few records of which members of the family were present when health practitioners engaged with Baksho. The efficacy of recording who else is present where there are safeguarding concerns is evident and signals to future practitioners the need to seek opportunities to see someone on their own. However, the recording of accompanying adults also provides an auditable trail of the individual's experience and can demonstrate the inclusion of family members, where appropriate, in their care and treatment.

Learning Point: Accompanying Adults

Practitioners should record who accompanies an adult in order to demonstrate familial support networks and which persons are involved in a caring role. It could also identify those who may pose a risk to an individual and signal the need to see someone on their own.

Recommendation 2: Accompanying Adults

Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that partner agencies are consistently recording who accompanies an adult is present during discussions and assessments

4.3. Selective Enquiry in Domestic Abuse

4.3.1. Domestic Abuse Statutory Guidance identifies the privileged role that health and social services have in identifying and responding to domestic abuse (Home Office, 2021). This sentiment is echoed by the Domestic Abuse Commissioner for England and Wales:

> "Health settings are trusted environments, used by everyone. Because of this, they are places we can reach those from every background and walk of

life subjected to domestic abuse, especially those who may not feel confident seeking help from other professionals." (Pathfinder,2020:2)

4.3.2. Selective enquiry about domestic abuse is therefore expected of front-line health and social care services where indicators of domestic abuse are present (National Institute for Clinical Excellence Standards QS116, 2016). Enquiry around domestic abuse can be undertaken either routinely, when all patients are asked, or selectively, when patients are only asked when they present with possible indicators. In the health setting that Baksho found herself in, having experienced an injury, it would have been expected that Emergency Department and social care staff would be making selective enquiries about domestic abuse with Baksho. In other health settings, selective enquiry into domestic abuse is seen as good practice, if not necessarily an expectation, in line with Making Every Contact Count (Public Health England and NHS England, 2016)

4.3.3. In the post-operative review, the doctor made enquiries about the cause of the fall which led to her broken hip and received an explanation of having fallen, which was consistent with Baksho's health and age, and which did not give cause for suspicion about intentional harm. This appeared to be a missed opportunity to directly ask her about domestic abuse, either then if it could be done safely, or at a later time when she was seen alone and with an interpreter present.

Learning Point: Selective Enquiry in Safe Environments
Healthcare professionals have a unique window of opportunity to respond to victims of domestic abuse.
All front-line health and social care staff should be equipped with the knowledge and skills they need to enquire about domestic abuse safely, sensitively and supportively through an explorative conversation.

4.3.4. In the intervening time, the Dudley Group has recruited a Domestic Abuse Co-ordinator to be responsible for the roll-out of the Trust's domestic abuse strategy and the co-ordination and delivery of domestic abuse training. The Trust has also introduced co-located Independent Domestic Violence Advisors (IDVAs) to the hospital in a partnership with Black Country Women's Aid. The IDVAs also check patient notes in the Emergency Department to ensure that indicators of domestic abuse have not been missed. These developments were recognised to be good practice and integral parts of a whole health response to domestic abuse in acute health settings (Pathfinder Toolkit,2020).

4.3.5. The review also recognised that much work had taken place to promote the Identification and Referral to Improve Safety (IRIS) programme in primary care across

the Dudley area, although this particular GP Practice had not yet received IRIS training. IRIS is a general practice based, domestic abuse, training, support and referral programme, which seeks to provide a skilled, care pathway for domestic abuse and is nationally recognised as good practice (Home Office, 2021). The Integrated Care Board has therefore recommended that this Practice received IRIS training and, through enhanced identification of abuse, makes referrals to the specialist domestic abuse worker to be aligned to the Practice[10]. It has also recommended that a bespoke domestic abuse policy be introduced into the Practice.

4.3.6. The Integrated Care Board recognised the central role of Practice Nurses in the identification of domestic abuse and has committed to provide safeguarding training for all Practice Nurses in the area, with a particular focus on identification of domestic abuse and neglect.

Recommendation 3: Selective Enquiry in Safe Environments
Dudley Safe and Sound to promote safe, targeted and selective enquiry into domestic abuse across front-line health and social services.

Dudley Domestic Abuse Local Partnership Board to seek assurance from front line health and social services that routine/ selective enquiry into domestic abuse is embedded into local policy and procedures, and routinely being undertaken, in keeping with the National Institute for Health and Care Excellence, Quality Standard QS 116

4.4. Confusion

4.4.1. The absence of an interpreter meant that on the two occasions notes when Baksho's possible confusion was noted in hospital, it would not have been possible to determine whether she was confused or not able to understand medical information and options provided by practitioners due to their inability to communicate with her. On both occasions the nurse and doctor documented that they were unable to understand or assess Baksho's confusion due to the language barrier. However, there is no evidence on either of these occasions that staff considered the use of an interpreter to assess if Baksho was confused.

4.4.2. Neither had it been possible for hospital staff to carry out dementia screening which would normally be routine for all patients aged over 65 years. This can often be the

[10] The IRIS Programme also provides guidance on the need to use interpreters and communicate in order that potential victims are both heard and understood.

first signal to staff that a patient may lack capacity to make some decisions and prompt further assessments when considering consent and decision making.

4.4.3. The Dudley Group reflected that there was a lack of insight from staff in providing a service which recognised the diversity of patients, and which promoted the accessibility of care. As a result, they have made a recommendation for themselves to update their Interpreter and Translation Policy to include use of interpreter for patients whose English is not their first language and present with current or new confusion

4.5. Discharge from Hospital and Domiciliary Care

4.5.1. Baksho's discharge from hospital was delayed for a couple of weeks whilst care and equipment arrangements were made for her return home and whilst waiting for the family to complete the necessary forms regarding the home environment. This was not considered to be an unusually long delay taking into account Baksho's age and the cause of her hospitalisation.

4.5.2. Adult Social Care were called upon to provide the assessment of Baksho's care needs before her discharge from hospital and thereafter provided a short period of domiciliary care and access to equipment. The assessment and the care provided was consistent with expected practice, and it was noted that there was good communication with Baksho's family in the discharge planning. No concerns were noted by the visiting domiciliary carers, although it was not recorded that Urgent Care's domiciliary carers were trained in identifying indicators of domestic abuse.

Learning Point: Training Domiciliary Carers in Domestic Abuse. Few practitioners have the opportunity to observe day-to-day life within an individual's home. By virtue of their discreet presence in the home environment, domiciliary carers have a unique role in identifying indicators of domestic abuse where they are present.
Recommendation 4: Training Domiciliary Carers in Domestic Abuse. Dudley Council to ensure that all front-line Adult Social Care staff, including carers, have been trained in identifying and responding to domestic abuse (see separate recommendation concerning private care providers below)

4.5.3. Since this time, Adult Social Care have introduced a process of home reviews to be undertaken within 72 hours after discharge from hospital. Had this been in place at the

time, Baksho's changing care needs at home could have been identified earlier and equipment ordered earlier. Significantly, it would have provided another opportunity to view the relationships at home and potentially seek to speak with Baksho alone.

4.5.4. On discharge from the Adult Social Care service, the records did not reflect a change of address for the GP and an individual recommendation has been made on this matter.

4.6. Follow -Up

4.6.1. The review noted that Baksho did not attend any of the three appointments at hospital for follow-up to her surgery and the GP Practice did not receive any of the notifications to this effect sent by the hospital on each occasion. Had they located the notifications, the GP Practice would have invited contact with Baksho, although, the review heard, that as in this case Baksho would not have been considered vulnerable by the GP Practice, this would not have been actively pursued by them beyond this invitation.

Recommendation 5: Follow-Up of 'Did Not Attends'
Dudley Integrated Care Board and Dudley Group to review the communication pathway to ensure that all notifications concerning 'did not attend' issued by the hospital are being received and, where necessary, followed up by primary care.

4.7. Falls prevention and domestic abuse

4.7.1. A history of falls should invite support by professionals to prevent further harm and a falls assessment in an older adult is a good opportunity to assess the individual holistically, particularly in the home environment. A falls assessment was undertaken when Baksho was admitted to hospital and arrangements put in place to manage her risk whilst she was an inpatient. On discharge, equipment was made available for her to manage her mobility at home.

4.7.2. The review was alerted to Dudley Fall Prevention Partnership, comprising each of the health agencies involved in this review. The partnership seeks to help prevent falls and increase mobility, confidence and independence for those who have already taken a fall.[11] The Partnership provides a detailed and informative brochure which is available to individuals as a guide to living independently at home. It concerns services which can support an individual after a period of illness or a hospital stay, helping them to return to independence. It provides "… information on the range of services available

[11] Further details of Dudley Falls Prevention Service can be found at https://www.dudley.gov.uk/resident/care-health/dudley-social-services/support-to-stay-at-home/dudley-falls-prevention/

to help you keep safe, secure, happy, well and independent in your own home." However, the brochure does not refer to domestic abuse and sources of help and online, it was not evident that information was available in community languages

4.7.3. Whilst is it not known in this case whether Baksho's earlier fall was indeed accidental, as reported, or the result of abuse, the circumstances alerted the panel to the fact that a propensity to falls as a result of frailty due to older age, disability or ill-health, could easily disguise abuse in these populations.

Learning Point: Domestic abuse disguised as a propensity to falls

Domestic abuse in older populations can easily be disguised as frailty and a propensity to falls. Practitioners should be engaging victims of falls in safe, sensitive, exploratory conversations and enquiry into domestic abuse.

Recommendation 6: Falls prevention and domestic abuse

Dudley Domestic Abuse Local Partnership Board to recommend to Dudley Falls Prevention Partnership that a domestic abuse focussed review of its policies and procedures is undertaken to ensure
(a) that routine enquiry on domestic abuse is systematically included in assessments pre and post discharge after there has been an injury from a fall when considering falls prevention advice with an individual and
(b) that public information signposts potential victims of domestic abuse to sources of help
(c) that written awareness materials are also made available in the main community languages in the area.

4.8. Equality and Diversity

Unconscious bias regarding the Sikh community

4.8.1. We have seen that as a result of language barriers, Baksho did not have parity of treatment in respect of decisions on her care and treatment and may not therefore have provided fully informed consent. We have also seen how she was not able to speak safely with a professional on her own and, in so doing, have the opportunity to disclose any abuse that she may have experienced abuse prior to the homicide. In this way, practitioners appeared confident in their reliance upon the family to interpret for her. The panel reflected whether this confidence may have been based upon cultural assumptions about the role of the family in Sikh communities and this assumption may also have extended to the expectation that the family in Sikh communities will take on

the caring role. The effect of these decisions was to provide a barrier to Baksho, as an older Sikh woman who spoke little English, to disclosing domestic abuse and seeking help, had she wanted to.

4.8.2. There has been little academic research into domestic abuse in the Sikh/Panjabi community (Aujila et al. 2019). However, a recent survey undertaken by Sikh Women's Aid has indicated that domestic abuse is particularly hidden in the Sikh community. The same survey recognised that risks for Sikh/ Panjabi women, and the barriers that they face, are akin to other Black and minoritised women in so far as there was widespread mistrust of agencies, fear of racism and its consequent under-reporting and extended length of time in an abusive relationship. SafeLives' dataset of 42,000 people found that Black and minoritised women suffered abuse for 1.5 times longer before seeking help, compared to women of white British background (cited in Sikh Women's Aid, 2021:17). The author of the report, Sahdaish Pall BEM, stated:

> *"Out of all the South Asian communities, Sikh women are the least likely to come forward about abuse. We come across as a very affluent, educated and giving community, and that reputation makes it very difficult for Sikh women to come forward," (Waheed, 2021)*

Learning Point: Black and minoritised women may experience additional barriers to identifying, disclosing, seeking help or reporting abuse including:

- A mistrust of agencies
- A fear of racism and racial stereotyping
- Language barriers
- Fear of rejection by family and wider community
- Intersecting identities will compound the barriers that they face

Recommendation 7: Black and minoritised women
Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with agencies and the public that domestic abuse occurs across communities and seek assurance that partner agencies are working effectively to address the barriers that Black and minoritised women face, including challenging prejudice and stereotypes that restrict the options available to them.

Unconscious bias towards older people

4.8.3. At the same, unconscious bias concerning older people's experience of domestic abuse is commonplace, and abuse amongst older generations often minimised or ignored (APPG, 2018). This may also have affected the response of practitioners in the contact

that they had with Baksho. Abuse of older victims is often obscured by a victim's health and social care needs, and we have seen how reasonable explanations of Baksho's earlier fall may have similarly obscured experiences of abuse without further exploration.

4.8.4. Research has found that common generational attitudes mean that older women may be less likely to identify their experiences as abuse and less likely to want to discuss it with professionals, combining a "generational invisibility" with a "generational silence" (SafeLives, 2016). This is reflected in the comparatively low level of referrals for older women that are made nationally to domestic abuse services (ibid).

4.8.5. The review heard how CHADD, a domestic abuse service in Dudley, provided specialist refuge accommodation and support for older people who have been victims of domestic abuse as well as bespoke Independent Domestic Violence Advisors (IDVAs) for older people in a programme called "Never too Late". Moreover, and as a result of the training needs analysis undertaken in preparation for the implementation of the Domestic Act 2021, Dudley Domestic Abuse Local Partnership Board identified the need to raise awareness and responses to domestic abuse in older people lives and has established a bespoke task group to address this. Within the necessary actions identified to date, Black Country Women's Aid will be providing e-learning, resource packs and toolkits[12] on older people and domestic abuse specifically. A short video highlighting how older people experience domestic abuse has already been shared widely amongst the Board's local partner agencies and with the public.[13] In these ways, Dudley could be seen to have placed the needs of older people experiencing domestic abuse firmly in place in its local response to domestic abuse.

4.8.6. The review also heard that the regional strategic group for domestic abuse is exploring the evidential need to adapt domestic abuse risk assessments to adequately reflect the risks that older people may face as indicated in the work of the Older People's Commissioner for Wales who piloted age specific questions into their domestic abuse risk indicator checklist (Older People's Commissioner for Wales, 2017). Indeed, research has found that the Domestic Abuse, Stalking and Harassment and Honour-Based Violence Risk Identification Checklist (DASH RIC) was not being used to its full advantage for older people (Wydall et al., 2015). As a result, opportunities to detect domestic abuse and access specialist services for older people were being missed (Sharp-Jeffs & Kelly,2016).

[12] The toolkit will form part of the wider training package
[13] The video can be seen on this link *Domestic Abuse Can Happen To Anyone*

Learning Point: Domestic Abuse and Older People. A ‘generational invisibility’ and a ‘generational silence.’

Practitioners need to be aware that domestic abuse occurs across the age span and that older people face additional barriers to understanding their experiences as domestic abuse and in accessing help including that:

- They are less likely to identify their experiences as domestic abuse
- They are less likely to have lived with abuse for prolonged periods before getting help
- They may lack awareness of support services and less likely to want to discuss personal matters with professionals
- They may face isolation and fear disrupting family dynamics
- They are more likely to suffer from health problems, reduced mobility or other disabilities which can exacerbate their vulnerability to harm
- If they have intersecting identities, this will compound the barriers that they face

Domestic Abuse Statutory Guidance (2021) emphasises the importance of supporting older people to make safe and informed choices when seeking help and directs agencies to consider the Centre for Age, Gender and Social Justice’s Practitioner Guidance: Transforming the Response to Domestic Abuse in Later Life[14] to improve their responses.

Recommendation 8: Domestic abuse and older people

Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with the public that domestic abuse occurs across the age span and advertise the help that is available.

Once its toolkit[15] for working with older people is developed and implemented, Dudley Domestic Abuse Local Partnership Board should monitor the numbers of older people being referred into services and seek assurance that partner agencies are working to effectively address the barriers that older people face, including challenging prejudice and stereotypes that restrict the options available to them.

[14] Available at https://dewischoice.org.uk/wp-content/uploads/2021/12/Practitioner-guidance-document-English-epdf_compressed.pdf

[15] The toolkit will form part of the wider training package

4.9. Private care companies

4.9.1. Baksho received domiciliary care for a couple of months after leaving hospital. Initially this was provided by Urgent Care, under the local authority. Thereafter, private care arrangements were made with Tipton Care, who briefly reported no concerns regarding their carer's observations of Baksho's home relations, and Bewdley Care, who did not respond to requests for information.

4.9.2. Private companies are not required to engage with a domestic homicide review. Moreover, as these particular companies were privately engaged by the family to provide care, and not commissioned by local authority or health agencies, there were no levers to engage with either provider further. The review panel would have particularly liked to explore whether the care providers trained their staff to identify indicators of domestic abuse.

4.9.3. Domiciliary care providers will have a unique opportunity to see the day-to-day living arrangements and relationships at home for the individual they provide care for in a way that other professionals may not. The review therefore sought to make recommendations that would both strengthen the capacity within the private sector care provision to identify and respond to domestic abuse, as well as strengthen the levers for engagement with those private sector organisations that are commissioned by the public sector, in subsequent reviews at a local and national level.

Recommendation 9: Private Care Providers

Dudley's health and social care commissioners of domiciliary care to consider introducing contractual requirements that care providers have domestic abuse policies and provide training and support to their care workers in the identification and response to domestic abuse.

Recommendation 10: Private sector engagement with domestic homicide review

Dudley's health and social care commissioners to consider introducing contractual requirements that require contracted health and care services to fully co-operate with domestic homicide and safeguarding reviews.

Recommendation 11: Private sector engagement with domestic homicide review (National)
Dudley Safe and Sound to consider making recommendations to government to extend the persons and bodies responsible for engagement with domestic homicide reviews, under section 9(4) of the Domestic Violence Crime and Victims Act 2004, to include private sector companies engaged in the provision of health and social care services.

5. CONCLUSION

5.1. This review has considered the circumstances leading to the tragic homicide of Baksho and whilst agency involvement was brief, there have nonetheless been lessons to be learnt for all agencies in the area. The review found of most significance that older Black and minoritised women may face intersecting barriers to identifying their experiences of abuse as well as seeking and gaining help. Moreover, domestic abuse in older people's relationships could be obscured by reasonable explanations of why falls happen in frail populations. It also highlighted the unique position of health agencies in being able to identify and respond to domestic abuse when other agencies have not been alerted.

5.2. The individual and multi-agency recommendations from this review will be monitored until completion by Dudley Safe and Sound and fed into the strategic domestic abuse plan for the area in order to strengthen the multi-agency response to domestic abuse and seek to prevent domestic abuse in the future.

6. RECOMMENDATIONS

6.1. Overview Recommendations

Recommendation 1: Use of Interpreters
Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that interpreting services are being consistently used with individuals who may be at risk of domestic abuse.

Recommendation 2: Accompanying Adults
Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that partner agencies are consistently recording who accompanies an adult is present during discussions and assessments

Recommendation 3: Selective Enquiry in Safe Environments
Dudley Safe and Sound to promote safe, targeted and selective enquiry into domestic abuse across front-line health and social services.
Dudley Domestic Abuse Local Partnership Board to seek assurance from front line health and social services that routine/ selective enquiry into domestic abuse is embedded into local policy and procedures, and routinely being undertaken, in keeping with the National Institute for Health and Care Excellence, Quality Standard QS 116

Recommendation 4: Training Domiciliary Carers in Domestic Abuse. Dudley Council to ensure that all Adult Social Care front-line staff, including carers, have been trained in identifying and responding to domestic abuse

Recommendation 5: Follow-Up of 'Did Not Attends'
Dudley Integrated Care Board and Dudley Group to review the communication pathway to ensure that all notifications concerning 'did not attend' issued by the hospital are being received and, where necessary, followed up by primary care.

Recommendation 6: Falls prevention and domestic abuse

Dudley Domestic Abuse Local Partnership Board to recommend to Dudley Falls Prevention Partnership that a domestic abuse focussed review of its policies and procedures is undertaken to ensure

(a) that routine enquiry on domestic abuse is systematically included in assessments pre and post discharge after there has been an injury from a fall when considering falls prevention advice with an individual and

(b) that public information signposts potential victims of domestic abuse to sources of help

(c) that written awareness materials are also made available in the main community languages in the area.

Recommendation 7: Black and minoritised women

Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with agencies and the public that domestic abuse occurs across communities and seek assurance that partner agencies are working effectively to address the barriers that Black and minoritised women face, including challenging prejudice and stereotypes that restrict the options available to them.

Recommendation 8: Domestic abuse and older people

(i) Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with the public that domestic abuse occurs across the age span and advertise the help that is available.

(ii) Once its toolkit for working with older people is developed and implemented, Dudley Domestic Abuse Local Partnership Board should monitor the numbers of older people being referred into services and seek assurance that partner agencies are working to effectively address the barriers that older people face, including challenging prejudice and stereotypes that restrict the options available to them.

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Dudley Safe and Sound to consider making recommendations to government to extend the persons and bodies responsible for engagement with domestic homicide reviews, under section 9(4) of the Domestic Violence Crime and Victims Act 2004, to include private sector companies engaged in the provision of health and social care services.

6.2. Individual Agency Recommendations

Dudley Council Adult Social Care

- 72hr post discharge review to be carried out for all urgent care referrals, to ensure any changes in need or identification of aids and adaptations are confirmed in a timely manner.
- Discharge team to review discharge documentation prior to discharge.

Dudley Integrated Care Board

- Provide IRIS training for the practice
- Facilitate safeguarding training for all Practice Nursing Staff in Dudley.
- Introduce a domestic abuse policy in the GP Practice concerned

Dudley Group NHS Foundation Trust

- Raise awareness and accessibility around use of interpreters
- Raise awareness of staff that they must document who else is present, including friends, family, interpreter at every contact as part of their record keeping
- Continue to raise awareness and highlight the need for staff to obtain the wishes and feeling of patients in their care and discharge planning arrangements

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DHR 5 ACTION PLANS – This action plan is a live document and subject to change as outcomes are delivered.

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Overview Recommendations

Recommendation 1: Use of Interpreters Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that interpreting services are being consistently used with individuals who may be at risk of domestic abuse.							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
1.1	Each partner agency ensures that effective policy is in place around use of interpreters when meeting clients.	Chair of Dudley Domestic Abuse Local Partnership Board	July 2023 (DDALPB Board meeting)	Each partner agency is able to provide reassurance that existing policy is in place* and evidence of a review of this has taken place to ensure it is fit for purpose (*this may not be a stand-alone policy but within other existing policies)	Report into DDALPB	Evidence provided that correct policy is in place and interpreting services are being consistently used with individuals who may be at risk of domestic abuse in order to enable safe disclosure of domestic abuse unmediated by family members	DDHR5 1.1.docx Completed Green
1.2	Each partner agency to give the DDALPB assurance that practitioners are compliant with the policy	Chair of Dudley Domestic Abuse Local Partnership Board	July 2023 (DDALPB Board meeting)	Assurance that policies are being adhered to by each agency	Report into DDALPB	Through a Domestic Abuse case file audit / Multi-Agency Assurance of Practice	DDHR5 1.2.docx Completed Green

Recommendation 2: Accompanying Adults Dudley Domestic Abuse Local Partnership Board to seek evidence-based assurance from its partner agencies that partner agencies are consistently recording who accompanies an adult is present during discussions and assessments.							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
2.1	Each partner agency ensures that effective policy is in place around recording adults present when meeting clients	Chair of Dudley Domestic Abuse Local Partnership Board	July 2023	Each partner agency is able to provide reassurance that existing policy is in place* and evidence of a review of this has taken place to ensure it is fit for purpose (*this may not be a stand-alone policy but within other existing policies)	Report into DDALPB	Evidence provided that correct policy is in place	DDHR5 2.1.docx Completed Green
2.2	Each partner agency to give the DDALPB assurance that practitioners are compliant with the policy	Chair of Dudley Domestic Abuse Local Partnership Board	July 2023 (DDALPB Board meeting)	Assurance that policies are being adhered to by each agency	Report into DDALPB	Through a Domestic Abuse case file audit / Multi-Agency Assurance of Practice	Completed – MAAF completed Sept 2023

Recommendation 3: Selective Enquiry in Safe Environments Dudley Safe and Sound in conjunction with Dudley Safeguarding People Partnership promote safe, targeted and selective / routine enquiry / professional curiosity into domestic abuse across front-line health and social services. Dudley Domestic Abuse Local Partnership Board to seek assurance from front line health and social services that routine/ selective enquiry into domestic abuse is embedded into local policy and procedures, and routinely being undertaken, in keeping with the National Institute for Health and Care Excellence, Quality Standard QS 116							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
3.1	To understand the training offer / communications from DSPP in relation to selective / routine enquiry / professional curiosity	Head of Adult Safeguarding & Principal Social Worker Head of Safeguarding, Practice and Quality Assurance (Childrens)	July 2023 (DDALPB meeting)	To promote safe, targeted and selective / routine enquiry / professional curiosity into domestic abuse across front-line health and social services.	Report to DDALPB	Through a Domestic Abuse case file audit / Multi-Agency Assurance of Practice	19.05.23 New Multi-Agency course_ Professional (Completed Green
3.2	Front line health and social services ensure that effective policy is in place around routine/ selective enquiry into domestic abuse	Chair of Dudley Domestic Abuse Local Partnership Board	July 2023	Relevant partner agencies are able to provide reassurance that existing policy is in place* and evidence of a review of this has taken place to ensure it is fit for purpose (*this may not be a stand-	Report into DDALPB	Evidence provided that correct policy is in place	DDHR5 3.2.docx Completed Green This also links to 1-2 recommendations

				alone policy but within other existing policies)			
3.3	Front line health and social services to give the DDALPB assurance that practitioners are compliant with the policy	Chair of Dudley Domestic Abuse Local Partnership Board	July 2023 (DDALPB Board meeting)	Assurance that policies are being adhered to by each agency	Report into DDALPB	Through a Domestic Abuse case file audit / Multi-Agency Assurance of Practice	DDHR5 3.3.docx Completed Green

Recommendation 4: Training Domiciliary Carers in Domestic Abuse. Dudley Council to ensure that all front-line Adult Social Care staff, including carers, have been trained in identifying and responding to domestic abuse							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
4.1	DMBC to ensure that all front-line Adult Social Care staff, including carers, complete the appropriate DA Training	Head of Adult Safeguarding & Principal Social Worker	October 2023	All DMBC front-line Adult Social Care staff, including carers will have completed the appropriate training, and cared-for individuals, who may otherwise be isolated from sources of support have the opportunity to disclose domestic abuse safely and their safety is protected.	Internal training reports	Relevant staff will have completed the training and therefore improved knowledge around DA	All DA training is assigned to job roles in DMBC, and compliance is monitored via a central Training Matrix and quarterly audits. Completed Green

Recommendation 5: Follow-Up of 'Did Not Attends' Black Country Integrated Care Board and Dudley Group to review the communication pathway to ensure that all notifications concerning 'did not attend' issued by the hospital are being received and, where necessary, followed up by primary care.							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
5.1	To review the communication pathway to ensure that all notifications concerning 'did not attend' issued by the hospital are being received and, where necessary, followed up by primary care.	Designated Nurse for Safeguarding Adults - Black Country Integrated Care Board - Dudley place	April 2024	Assurance that the communication pathway to ensure that all notifications concerning 'did not attend' issued by the hospital are being received and, where necessary, followed up by primary care.	Through report to DDALPB via ICB Safeguarding Quality Review Meeting (SQRM)	Through a dip sample audit to assure that notifications are being followed up	All providers have a DNA/WNB policy in place – evidenced through Safeguarding dashboards. Letters are sent from acute and specialist services to the GP practice when the pt does not attend appointments- this has been evidenced through MACF audits

Recommendation 6: Falls prevention and domestic abuse.
Dudley Domestic Abuse Local Partnership Board to recommend to Dudley Falls Prevention Partnership that a domestic abuse focussed review of its policies and procedures is undertaken to ensure.
(a) that routine enquiry on domestic abuse is systematically included in assessments pre and post discharge after there has been an injury from a fall when considering falls prevention advice with an individual and
(b) that public information signposts potential victims of domestic abuse to sources of help.
(c) that written awareness materials are also made available in the main community languages in the area.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
6.1	Dudley Falls Prevention Partnership to review and update current policy and procedures with a focus on Domestic abuse	Dudley Falls Prevention Partnership Chair	October 2023	Dudley Falls Prevention Partnership to provide assurance that policy and procedures have been reviewed and that routine enquiry on domestic abuse is systematically included in assessments pre and post discharge after there has been an injury from a fall	Report into DDALPB	Potential Domestic Abuse is identified, and support offered as appropriate. Increase in referrals into specialist services	The Access Team in Adult Social Care acts as the single point of access for all referrals related to falls. If a safeguarding concern was alerted, this would be raised by the duty officer. There is an established pathway for communicating any concerns to DMBC's multi-agency safeguarding team (MASH). Once a suspected risk has been flagged, all

							safeguarding concerns are dealt with by MASH following national legal guidance.
6.2	Public information developed by Dudley Falls Prevention Partnership signposts potential victims of domestic abuse to sources of help (Dudley SPOC) and that this information is made available in the main community languages in the area	Dudley Falls Prevention Partnership Chair	October 23	Individuals from all communities, irrespective of age, who experience falls are aware of how to access specialist Domestic Abuse Support	Report into DDALPB	Increase in referrals into specialist services	A new leaflet is in development. The content of the leaflet is aimed at adults, to promote physical activity, in particular strength and balance exercises and where to get further help and support to reduce their risk of falls. We do not plan to have translated versions of the leaflet as we are working to budget restrictions. However, as with all our front-facing communications, we provide an

							alternative and will have wording along the lines of: "If you require any assistance with regards to this document or would like to request an interpreter large print or audio version, please contact XXXX". However, it is important to point out that where falls is not primarily caused by modifiable risk factors such as mobility, vision impairment, medication, environmental hazards etc then they are not likely to be appropriate for the integrated falls service. Any concerns relating to safeguarding will be

							identified and raised during the point of access and will be referred to other specialist services.

Recommendation 7: Black and minoritised women
Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with agencies and the public that domestic abuse occurs across communities and seek assurance that partner agencies are working to effectively address the barriers that Black and minoritised women face, including challenging prejudice and stereotypes that restrict the options available to them.

REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
7.1	Safe and sound to promote targeted DA comms to minoritised communities	Chair of Dudley Domestic Abuse Local Partnership Board	April 23	Black and minoritised women in Dudley who are experiencing domestic abuse have confidence in agencies that are accessible and responsive to their needs.	Through comms reports into the DDALPB	Through an increase in engagement of Black and minoritised women with specialist services	Posters and leaflets have been translated into 6 of our community languages, additional communications will be carried forward in the 2024 – 2026 DDALPB action plan

7.2	DDALP to obtain assurance from partner agencies that the barriers faced by Black and minoritised women are considered is their working practices	Chair of Dudley Domestic Abuse Local Partnership Board	October 23	Ensuring that our services are available to and accessible by all of our communities and that professionals are aware of barriers faced by Black and minoritised women	Report to DDALPB	Through an increase in engagement of Black and minoritised women with specialist services Reports from Specialist Service Providers include breakdowns of protected characteristics	DDHR5 7.2.docx
7.3	DDALPB to ensure that the boroughs commissioned DA training offer covers barriers faced by minoritised communities	Chair of Dudley Domestic Abuse Local Partnership Board	April 24	Heightened awareness among practitioners around barriers minoritised communities face	Through report to DDALPB	Relevant staff will have completed the training and therefore improved knowledge around the barriers minoritised communities face	There is a section in the responding to DA course on different types of diversity as a barrier to seeking help, including diversity, which advises practitioners to seek advice from specialist organisations and aim for cultural competency, examples of specialist

							information signposted to: Specialist support and advice for people subjected to forced marriage and so-called honour-based abuse: National: Forced Marriage Unit National: Karma Nirvana UK Helpline Multi-language versions of the DASH risk assessment: DASH in multiple languages There is also a section on so-called honour-based abuse and forced marriage in there as well as the more detailed stand-alone course.

Recommendation 8: Domestic abuse and older people Dudley Domestic Abuse Local Partnership Board should continue to raise awareness with the public that domestic abuse occurs across the age span and advertise the help that is available. Once its toolkit[1] for working with older people is developed and implemented, Dudley Domestic Abuse Local Partnership Board should monitor the numbers of older people being referred into services and seek assurance that partner agencies are working to effectively address the barriers that older women face, including challenging prejudice and stereotypes that restrict the options available to them.							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
8.1	DDALPB to ensure that awareness raising continues as part of the wider safe and sound communications plan	Chair of Dudley Domestic Abuse Local Partnership Board	Ongoing	Increased awareness that Domestic Abuse affects all ages and increased awareness of the specific support available for older people within the borough	Evidence of relevant messaging that has been shared	Through an increase in engagement of older people with specialist services	Work has already taken place around this with the creation of a short video specifically aimed at older people and comms that were delivered along side it. Additional communications will be carried forward in the 2024 – 2026

[1] The toolkit is part of the wider training package.

							DDALPB action plan. This is green
8.2	DDALP to monitor the take up of the training and resources in respect of Domestic Abuse and older people	Chair of Dudley Domestic Abuse Local Partnership Board	Ongoing	Staff will have completed the training appropriate to their role.	Through quarterly training reports to DDALPB	Relevant staff will have completed the training and therefore improved knowledge around older people and Domestic Abuse, in addition, through an increase of 'professional' referrals into specialist services	An older people and DA course has been developed as part of the wider DA training offer, take up of training is monitored and reported into the DDALPB quarterly. CHADD have also delivered additional training courses.
8.3	DDALPB to monitor the numbers of older people being referred into services	Chair of Dudley Domestic Abuse Local Partnership Board	ongoing	An increase of referrals of older people into domestic abuse services	Through quarterly training reports to DDALPB	Through an increase in engagement of older people with specialist services	Quarterly reports are received by the DDALPB in respect of the specialist services within the borough including the specific older peoples service

							we have within the borough; these include age breakdown and referral sources
8.4	DDALPB to seek updates from partner agencies in respect of their responses to effectively address the barriers that older women face, including challenging prejudice and stereotypes.	Chair of Dudley Domestic Abuse Local Partnership Board	October 23	Ensuring that our services are available to and accessible by older people within the borough	Report to DDALPB	Through an increase in engagement of older people with specialist services	DDHR5 8.4.docx

Recommendation 9: Private Care Providers Dudley health and social care commissioners of domiciliary care to consider introducing contractual requirements that care providers have domestic abuse policies and provide training and support to their care workers in the identification and response to domestic abuse.							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
9.1	DMBC to ensure that contracts with externally commissioned	Head of Adult Safeguarding & Principal Social Worker	April 2024	Contracts updated as appropriate	Evidence of inclusion in contracts	Relevant staff will have completed the training and therefore improved	6/3/24 Completed Green.

	carers include a requirement for staff to complete the appropriate DA Training				and training reports	knowledge around DA, leading to older people in Dudley who are experiencing domestic abuse to have confidence in agencies that are accessible and responsive to their needs	All contracts now include specific requirement for staff to complete safeguarding training including DA training.
9.2	Health partners to ensure that safeguarding and DA training is including in the NHS standard contract	Designated Nurse for Safeguarding Adults - Black Country Integrated Care Board - Dudley place	October 2023	Assurance that safeguarding and DA training is including in the NHS standard contract	Report to DDALPB	Relevant staff will have completed the training and therefore improved knowledge around DA, leading to older people in Dudley who are experiencing domestic abuse to have confidence in agencies that are accessible and responsive to their needs	NHS Standard Contract includes Domestic abuse in the section 32 of the contract. Domestic Abuse Training are included in the quarterly Dashboards from providers and Annual GP Safeguarding Assurance Framework

Recommendation 10: Private sector engagement with domestic homicide review (Local) Dudley's health and social care commissioners to consider introducing contractual requirements that require contracted health and care services fully co-operate with domestic homicide and safeguarding reviews							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
10.1	DMBC to ensure that contracts with externally commissioned carers include a requirement to fully co-operate with domestic homicide and safeguarding reviews	Head of Adult Safeguarding & Principal Social Worker	April 2024	Contracts updated as appropriate	Evidence of inclusion in contracts	Increased engagement as appropriate in future reviews	Green 6/3/24 All contracts with externally commissioned carers include a requirement to fully co-operate with domestic homicide and safeguarding reviews. SAFER 7 developed to increase awareness within Community Providers on their role and responsibilities to participate in DHR reviews

Recommendation 11: Private sector engagement with domestic homicide review (National) Dudley Safe and Sound to consider making recommendations to government to extend the persons and bodies responsible for engagement with domestic homicide reviews, under section 9(4) of the Domestic Violence Crime and Victims Act 2004, to include private sector companies engaged in the provision of health and social care services.							
REF	Action (SMART)	Lead Officer	Target date for completion	Desired outcome of the action	Monitoring arrangements	How will Success be Measured and Outcome	Rag rating and Narrative
1.1	To make consideration for private sector companies to be made statutory partners in DHRs where appropriate	Home Office DHR QA Group		Inclusion of private sector companies as statutory partners in DHRs where appropriate	Response from Home Office DHR QA Group	Inclusion of private sector companies as statutory partners in DHRs where appropriate	

Individual Agency Recommendations for Adult Social Care

Recommendation 1: 72hr post discharge review to be carried out for all urgent care referrals, to ensure any changes in need or identification of aids and adaptations are confirmed in a timely manner.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	72hr review to be included in Pathway 1 discharge.	Local	Team Manager – Urgent Care	Currently insitu in hospital discharge pathway procedures.	Comple ted	Completed Green Currently in hospital discharge pathway procedures.

Recommendation 2: Urgent Care hospital discharge team to complete pre-discharge checks for patient.

REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
2.1	Pre discharge checks to be included in discharge planning tasks.	Local	(Role in org) Team Manager Urgent Care	Minimising the risk for inaccurate information being used post discharge from hospital.	Apr 2022	DGFT- A discharge checklist is completed prior to transfer from hospital.

Individual Agency Recommendations for Black Country Integrated Care Board – Dudley Place

Recommendation 1: IRIS training for the practice						
REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
1.1	The Practice will complete IRIS training to equip staff with the knowledge and skills to identify Domestic Abuse and refer to the Advocate Educator. There will be an increased awareness following training and referrals will increase between session one and two.	Local	Safeguarding Lead GP	Complete both sessions. Refer Patients to the Advocate Educator on identification of Domestic Abuse	June 2022	IRIS clinical One and two completed plus reception staff – BCWA IRIS workers receiving referrals form Practice

Recommendation 2: Practice Nurse training						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
2.1	Designated Safeguarding team to facilitate Safeguarding training for all Practice Nursing Staff in Dudley. Increase knowledge and skills in identifying abuse and neglect.	Local	Designated Nurse for Safeguarding Adults - Black Country Integrated Care Board - Dudley place	Attend a training session delivered by the Designated Nurses. Evaluate the training and identify further training needs if required.	Sept 2022	Completed – training delivered. Sept 2022

Recommendation 3: Domestic Abuse policy						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	The practice has a Safeguarding policy, but Domestic Abuse is not included. Review of the current policy and either inclusion of domestic abuse or a bespoke Practice Policy for Domestic Abuse.	Local	Safeguardin g Lead GP/Practice Manager	Review Policy and include domestic abuse. Launch policy at practice and raise awareness.	June 2022	Primary Care/GP DA policy and guidance has updated across the Black Country ICB has been completed and ratified which reflects the changes in policy. Sept 2024

Individual Agency Recommendations for Dudley Group NHS Foundation Trust

Recommendation 1: Raise awareness and accessibility around use of interpreters.						
Desired outcome from the recommendation: Increase in staff accessing and utilising interpreting service since 2018.						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
1.1	Patient safety bulletin to be distributed across the Trust	Local	Head of Safeguarding			This was completed in Oct 2021
1.2	Staff to have access to telephone interpreter lines and interpreter app	Local	Patient Access Team			Completed Oct 2021
1.3	Interpreter and Translation Policy to include use of interpreter for patients whose English is not their first language and present with current or new confusion	Local	Patient Access Manager	Policy due for review May 2022	June 2022	Policy reviewed and updated 04/08/23.

Recommendation 2: Raise awareness of staff that they must document who else is present, including friends, family, interpreter at every contact as part of their record keeping						
Desired outcome from the recommendation: There will be an auditable trail of who is present when staff consult with and assess patients – can be evidenced as part of safeguarding documentation audits						
REF	Action (SMART)	Scope	Lead	Key milestones	Target date	Completion Date and Outcome
2.1	To be included in the Trust record keeping training	Local	Trust Learning and Development Lead		April 2022	This is included across all levels of DGFT Safeguarding training.
2.2	Patient Safety Bulletin	Local	Safeguarding Adult Team/Learning and Development Lead		April 2022	This was included in the Patient Safety Bulletin regarding interpreters. DGFT are currently completing an audit in relation to DA and further bulletins will be included as part of a wider piece of work.
2.3	Continue to promote this practice in all safeguarding and domestic abuse training	Local	Safeguarding Team			This currently happens across all levels of safeguarding and domestic abuse training
2.4	Audit of safeguarding records to include evidence of improvement in documenting who is present during consultation and assessment of patients.	Local	Adult Safeguarding Team	Audit will commence in Oct/Nov 2022 and be ready for presentation to Internal Safeguarding Board in January 2023	Dec 2022	This has not been achievable due to capacity within the team. However, this will be addressed as part of the 2023-24 audit programme.

Recommendation 3: Continue to raise awareness and highlight the need for staff to obtain the wishes and feeling of patients in their care and discharge planning arrangements.						
Desired outcome from the recommendation: Evidence of voice of the adult in safeguarding documentation audit						
REF	**Action (SMART)**	**Scope**	**Lead**	**Key milestones**	**Target date**	**Completion Date and Outcome**
3.1	Patient Story to be presented to Internal Safeguarding Board and shared across Divisions	Local	Adult Safeguarding Team		April 2022	Completed and presented in April 2023.
3.2	Continue to raise awareness of patient's voice in all levels of safeguarding training	Local	Safeguarding Team		Feb 2022	This is a continuous message throughout all training. Training is now going back to face to face, and it is anticipated that this will have a bigger impact on staff understanding of this.
3.3	Audit of safeguarding records to evidence improvement in patient's wishes and feelings being sought and documented	Local		Audit will commence in Oct/Nov 2022 and be ready for presentation to Internal Safeguarding Board in January 2023	Dec 2022	This has not been achievable due to capacity within the team. However, this will be addressed as part of the 2023-24 audit programme.

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23 November 2023

Dear Katriona,

Thank you for submitting the Domestic Homicide Review (DHR) report (Baksho) for the Dudley Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 11th October 2023. I apologise for the delay in responding to you.

The QA Panel felt this was a thoughtful and probing report with a good use of research and well-developed learning points and conclusions.

The report benefited from the close questioning of health and social care agencies to elicit as much information as possible as well as a helpful focus on unconscious bias, language barriers, abuse of older people and barriers to reporting experienced by black and minority women.

Nonetheless the QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The report uses words such as ‘tragic accident’ as opposed to homicide/murder.

- Both the recommendations and action plan need further work to follow through on whether timelines were met and to identify specific outcomes.

- It was accepted that Baksho’s family would interpret for her, although when she was admitted to hospital following the fall, the hospital had a ‘Interpretating and Translation Policy’ in place. It was not recorded whether she was asked if she wanted an interpreter and if she had consented for her

family to do so. This was not recorded, despite Baksho being in hospital for a month.

- A key matter missing from the Executive Summary is an explanation of the Chair's independence and details of their career history and experience.

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 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 Panel feedback letter 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 Panel, 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 Panel