SAFER SANDWELL PARTNERSHIP DOMESTIC HOMICIDE REVIEW – ANGELA, WHO DIED IN 2022

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Independent Chair and Author | DHR completed December 2024

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1 Introduction to the Domestic Homicide Review (DHR)

1. **The DHR Chair and panel would wish to express their sincere condolences to the family, friends, and colleagues of Angela for their loss.**
2. This report of a Domestic Homicide Review examines agency responses and support offered to Angela, a resident of Sandwell prior to the point of her death in 2022.
3. The DHR looked at the level and quality of engagement agencies had with Angela but also the perpetrator to identify whether there were opportunities to discover the presence of domestic abuse and provide pathways to access support in the community. The DHR also examined whether there were missed opportunities to offer such support or a failure to recognise barriers to accessing that support. The purpose of a DHR is to take a holistic approach in order to identify learning and improve community safety.
4. The Safer Sandwell Partnership (SSP) Board were notified of the homicide and commenced a DHR after considering the circumstances and agreeing that they met the criteria set under the Domestic Violence, Crime and Victims Act 2004 that the death of Angela 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) a member of the same household as herself.
5. The DHR considered agencies involvement with Angela and Miles between 2020 (Miles entered the country in early 2020) and Angela's death in 2022. Agencies were asked to also include historic information they consider relevant to allow the DHR a better understanding of Angela's lived experience.
6. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. 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 to reduce the risk of such tragedies happening in the future.

2 Timescales

1. This DHR began in early 2023 when the Domestic Homicide Review Standing Panel and Safer Sandwell Partnership Board (SSPB) agreed that the circumstances of the case met the criteria for a DHR. They appointed an Independent Chair in February 2023. The panel met and set terms of reference in March 2023, and met again in May 2023 to consider submissions to the review, and September 2023 to consider the Overview report. The DHR ended in December 2023 when the Safer

Sandwell Partnership Board accepted the Overview Report and agreed it should be submitted to the Home Office. The Home Office returned the report for publication in July 2024. The Home Office feedback was incorporated into the final report in December 2024.

3 Confidentiality

1. The findings of the DHR are confidential and information is only available to participating agencies senior managers, frontline professionals involved in the case and their line managers. To protect as far as possible to the privacy of the surviving family in this case, pseudonyms have been used for the victim and perpetrator. In the absence of family involvement with the DHR the names used were chosen by the DHR panel.

Angela	The victim was of Black Caribbean origin and was 55 years old at the time of her death
Miles	The perpetrator was of Black Caribbean origin and was 54 years old at the time of Angela's death
Anton	The victim's adult son

4 Terms of Reference

1. The aim of the domestic homicide review (DHR) is to:

- Establish the facts that led to the incident in 2022 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.
- 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.
- Identify clearly what these 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.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all victims of domestic violence and abuse, and their children, by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.

2. The review should address both the 'generic issues' set out in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this case.

3. ***IMPORTANT NOTES: Independent Management Review (IMR) authors and authors of helpful reports should, in addressing the terms of reference or the agency specific questions below, identify whether COVID restrictions led to operational or capacity issues that impacted negatively upon the quality and effectiveness of their staff's contacts with any of the parties subject to this review. Please identify measures taken that, with hindsight, could provide effective learning related to the COVID period.***

4. ***The Safer Sandwell Partnership has included with this Terms of Reference details of key learning and recommendations from Sandwell DHRs that have identified similar themes to those in this DHR. Please include in your IMR/report an update on progress in relation to any single agency or strategic recommendations that related to your agency.***

5. All agencies should address the generic questions above but, in addition to this, there are some specific issues that should be addressed by the following agencies. In response to the initial scoping from agencies, the DHR Panel has identified the following key lines of enquiry which should be considered when answering any agency specific questions.

Key Lines of Enquiry (KLOEs)

KLOE: 'Asking the Question'; a responsibility to identify potential domestic abuse

NICE Public Health Guidelines (PH50) 2014 and the Domestic Violence and Abuse (Quality Standard 116) 2016 describe best practice in relation to the commissioning of domestic abuse services and supporting patients experiencing domestic abuse. They describe the circumstances in which health agencies should either routinely ask questions relating to domestic abuse when first encountering patients or ask questions relating to the possible experience of domestic abuse when a patient presents with a health condition included in a list of potential indicators of domestic abuse.

The scoping identified possible missed opportunities to 'ask the question' of Angela (victim) and Miles (perpetrator) about whether they were experiencing domestic abuse. In addition, Anton (Angela's son) received mental health support over a number of years and, since 2016, best practice as recommended in NICE guidance has been that mental health services should routinely ask whether a service user's mental health is related to domestic abuse.

Questions for the Black Country Integrated Care Board

1. Identify the extent to which NICE QS 116 (2016) and PH 50 2014 concerning 'asking the question', when a patient presents to primary care and mental health support with health indicators that could indicate they are potentially at risk of domestic abuse, are embedded in the Black Country and evaluate its effectiveness.
2. Were appropriate questions asked of Angela relating to domestic abuse, in line with NICE Guidance (2016)?
3. Describe any measures taken the Black Country ICB, to embed the NICE Guidance relating to asking the question when a patient presents to a GP surgery with health indicators that could indicate they are experiencing domestic abuse?
4. Identify whether the current safeguarding self-assessment required of GP practices allows for reporting of the number of referrals made by a practice to Identification and Referral for Improved Safety (IRIS) advocate educators or other domestic abuse support services, following DA disclosures.
5. What guidance was issued by Black Country ICB during COVID to GP surgeries relating to their duty of care towards patients possibly experiencing DA? (Provide copies of guidance where possible) Describe what best practice should have looked like during that period.
6. In relation to Angela's mental health, please summarise any GP encounters (including those outside of the timeline) that related to depression, anxiety, and stress. (Please identify clearly which encounters were face-to-face and which were on the phone).

Questions for Black Country Women's Aid (BCWA**) and Black Country ICB**

1. Identify whether the GP practices used by Angela, Miles, or Anton in this case, are IRIS trained? (Note: the ICB in their interviews with key staff should identify their levels of training and understanding of 'asking the question').
2. Provide figures to illustrate the number of referrals made to IRIS advocate educators by the GPs practice used by Angela, Miles, and Anton in 2020, 2021 and 2022 to date.

3. Describe how the Black Country ICB and or Black Country Women's Aid audit the effectiveness of GPs practices in relation to asking the question and making referrals to IRIS advocate/educators. (Where no such audit is in place, identify how your agency could provide assurances to the Safer Sandwell Partnership that appropriate audits could be completed).
4. Describe the current uptake of IRIS in Sandwell practices and compare the current position with the rest of the Black Country Local Authority areas.
5. What guidance was issued by Black Country Women's Aid during COVID to IRIS trained GP surgeries relating to their duty of care towards patients possibly experiencing DA and ensuring continuity of support? (Provide copies of guidance where possible) Describe what best practice should have looked like during that period.
6. Provide details of the content of the IRIS package delivered by BCWA and specifically describe how (if at all) practitioners are taught and encouraged to 'ask the question' in an empathetic and effective manner. If BCWA identify any shortcomings in this area, suggest how they could be addressed locally and nationally.
7. Identify any changes to IRIS that have occurred or are planned that appear relevant to this KLOE.
8. The ICB should describe the commissioning and funding of BCWA and IRIS. The ICB should identify any elements of commissioning of BCWA that would allow for improvements to service delivery, should the DHR conclude such recommendations are appropriate.

Question for Black Country Healthcare NHS Trust

1. Identify from the point that Anton was first seen by CAMHS, any disclosure made or identification by professionals, of what would now be called child to parent or carer violence and abuse. (The DHR recognises that at the point that Anton started being supported, this form of abuse was not widely recognised).
2. Identify any disclosures made by Anton of domestic abuse, involving any members of his family.
3. Provide an assessment of Anton's relationship with parents and siblings.
4. Identify any disclosures made by Anton relating to contacts with his mother's husband, Miles, who apparently arrived in the UK in 2020.
5. Identify whether risk assessments used by Black Country Healthcare Trust specifically require professionals to 'ask the question' in line with NICE guidance.

6. Describe any recent changes to any risk assessments used by the Trust that would make it more likely professionals would identify the part domestic abuse may be playing in a patient's mental ill health.
7. Can BCHT identify and audit when their professionals provide DA support or make referrals in relation to patients experiencing DA? Provide details of referral rates.

Questions for Sandwell Adult Social Care Mental Health Team

1. In the autumn of 2020, an AMHP was involved in an assessment of Anton where he apparently was described as arguing with family and neighbours. Anton disclosed his family was 'unkind to him', but this was apparently ascribed to 'paranoia'.
2. Analyse this incident and identify whether practice in this case suggested an awareness of the part domestic abuse can play in relation to mental ill health.
3. Describe policy and procedures relating to 'asking the question' in relation to DA when an AMHP is asked to initiate a Mental Health Act assessment process.

KLOE: In the context of possible domestic abuse, identifying the potential significance of diabetes diagnoses in Angela and Miles's health presentations.

Questions for the Black Country ICB, Sandwell & West Birmingham Hospital Trust

1. Could Angela and Miles's non concordance with treatment for their diabetes lead to or exacerbate mental ill health and aggressive behaviours?
2. Should this have been considered by health professionals as a potential relevant additional risk factor where relationship problems are disclosed by either party?
3. Identify any potential learning points in relation to diabetes you feel would be appropriate to share with your staff as a result of your observations.

KLOE: Identify whether Miles's antecedent criminal history in any country outside the UK should have led to entry clearance refusal under Part 9 of the immigration rules Note: the DHR will pursue this KLOE with Border Force and Immigration if considered necessary.

Since 2012, Part 9, Paragraph 320(2) of the Immigration Rules provide mandatory grounds for refusal for people subject to a deportation order or who have been sentenced to a period of imprisonment. Accordingly, an application **must** be refused if:

the person seeking entry to the United Kingdom:

(a) is currently the subject of a deportation order; or

(b) has been convicted of an offence for which they have been sentenced to a period of imprisonment of at least 4 years; or

(c) has been convicted of an offence for which they have been sentenced to a period of imprisonment of at least 12 months but less than 4 years, unless a period of 10 years has passed since the end of the sentence; or

(d) has been convicted of an offence for which they have been sentenced to a period of imprisonment of less than 12 months unless a period of 5 years has passed since the end of the sentence.

Where this paragraph applies, unless refusal would be contrary to the Human Rights Convention or the Convention and Protocol Relating to the Status of Refugees, it will only be in exceptional circumstances that the public interest in maintaining refusal will be outweighed by compelling factors.

Questions for West Midlands Police

1. Identify whether the investigation into Angela's homicide has established if Miles had convictions in any country, which should have led to an entry clearance refusal. If so, is there any identified reason why there appeared to have been a failure to implement the Immigration rules in this case?
2. Are WMP aware of Miles having any antecedent domestic abuse history (reports or convictions) in any jurisdiction outside of the UK?

5 Methodology

1. The DHR took into consideration the restrictions imposed upon the public and agencies during the COVID pandemic. The review recognised that face-to-face contact during this period was often limited and access to services could be problematic.
2. The SSP requested information from key agencies concerning any involvement with parties to the review. (see section 7)
3. There were no interviews with family or friends. The Black Country ICB IMR author carried out a briefing with key staff from Angela and Miles' GP practice.

6 Involvement of Family, Friends, Work Colleagues, and wider Community

1. Family and friends of Angela were approached in writing at different stages of the DHR using the police Family Liaison Officer as an intermediary. The family made it clear that they did not wish to engage and preferred to concentrate on rebuilding their lives. Angela's closest friends did not respond to written invitations to participate.
2. The family were in contact with a Senior Caseworker from Victim Support however they declined support from Victim Support.
3. Angela's daughter expressed some interest in seeing the Overview report but did not progress this offer. The SSPB will ensure that interested parties are given advance notice of publication.

7 Contributors to the Review

1. IMRs were requested from the Black Country ICB and Sandwell Adult Social Care Mental Health Team. All other agencies responded to the KLOE questions. All IMRs and reports were written by safeguarding leads or managers who had neither involvement with the individual subject to review or responsibility for any of their agency actions.

8 The Review Panel Members

Role and organisation
Independent Chair and Overview Author
DHR research and administrative support
Domestic Abuse Team Manager Sandwell MBC
Director of Community Services Black Country Women's Aid (BCWA)
Designated Nurse – Adult Safeguarding – Black Country Integrated Care Board (ICB)
Interim Lead for Adults Black Country Healthcare Foundation NHS Trust (BCHFT)
Lead Practitioner: Adult Social Care Sandwell MBC
Sandwell Children's Trust – Business Manager Safeguarding & Practice Review
Adult Safeguarding Lead Sandwell & West Birmingham Hospital Trust (SWBHT)

Public Protection Unit West Midlands Police
Health & Wellbeing Services Manager – Sandwell African Caribbean Mental Health Foundation
Support Staff Safer Sandwell Partnership
Domestic Abuse Incident Review Coordinator Sandwell MBC

1. The members of the DHR panel were all entirely independent of the events detailed in the DHR. They had no management oversight or involvement in any of their agencies' engagements with either the victim, perpetrator, or family members.
2. The panel met formally on four occasions but, between panels updates, suggestions and research were shared between panel members through the SSP via secure email.

9 Author of the Overview Report

1. The Independent Chair of this DHR has had ten years' experience chairing DHRs and Safeguarding Adult Reviews (SARs). He is a retired officer from West Midlands Police (WMP) (retirement date Nov. 2013). He attended DHR Training in 2013, which at that period was provided by Against Violence and Abuse (AVA). During his service spent a large period on the Public Protection Unit investigating both child and adult safeguarding concerns in a multi-agency context. He was also responsible for the WMP Review Team contributing and overseeing WMP's Individual Management Reviews (IMRs) into both Child and Adult Statutory Reviews.
2. He retired before any of the events described in the timelines for this Review and is entirely independent of any of the encounters his former agency had with any of the parties to this review.

10 Parallel Reviews

1. HM Coroner conducted an Inquest and returned a verdict of unlawful killing.

11 Equality and Diversity

1. The nine protected characteristics under the Equality Act 2010 were considered.
2. The DHR identified possible evidence of a lack of understanding of cross-cultural working in relation to responses to domestic abuse and this is discussed in the analysis. The DHR received guidance on

dominant cultural attitudes and beliefs within Jamaican society and those found within Jamaicans resident in the UK from a local organisation, Sandwell African Caribbean Mental Health Foundation.

12 Dissemination

1. The DHR will be shared prior to submission to the Home Office with the members of the SPP and contributing agencies. The Office of the Police and Crime Commissioner for the West Midlands will have access to the report.
2. The Care Quality Commission will be appraised of the findings of the DHR in relation to recommendation four.

13 Background Information (the facts)

1. The DHR panel noted and respected Angela's family and friend's choices not to engage with the DHR but consequently the review is unable to provide the depth of background information that might have assisted in understanding Angela's lived experience.
2. Angela was of Jamaican origin; her mother and three siblings still live there. She arrived in the UK in 1999. She had two adult children, a son, Anton, and a daughter. Angela was previously married but divorced in 2017. Angela's son, Anton, suffered with significant mental ill health from adolescence into adulthood. Angela devoted all her energies to supporting her son and trying to provide a stable home, even though his ill health led to tensions with his mother and sibling and occasionally with neighbours.
3. Angela apparently met Miles at a party in Jamaica and they were married in 2017. Angela's son, Anton, did not approve of the relationship and later told Mental Health professionals he had not attended the wedding. According to Miles, they lived together in Jamaica for approximately two years, before he sought a visa to live in the UK with Angela. (It is not clear when these two years were, but it was probably from 2017 to some point in 2019). It is possible that Angela's desire to support her son was a factor in any decision concerning where the couple would live permanently.
4. Miles is also of Jamaican origin and has thirteen children, most of whom are adults although there are apparently several children under 18 living in Jamaica. The mother of his youngest children passed away during the COVID pandemic.
5. There was an uncorroborated allegation, obtained by Police during the murder enquiry, that Miles was domestically abusive toward his mother. These claims could not be corroborated because he refused to provide investigators with her details. The DHR was unable to gain reliable details of whether Miles had any relevant history of domestic abuse and criminal activity in Jamaica. The DHR

was however made aware of criminal activity in the USA dating from the mid 90s, when Miles was in his twenties.

6. Miles's offending included possession of a firearm, supply of drugs, false imprisonment, and witness intimidation. He was also arrested, but not convicted, for rape. Although not confirmed, the Police investigation revealed that these offences appeared domestic related. Having served a custodial sentence in the USA, Miles was deported to Jamaica upon release.

7. Miles applied to enter the UK in 2018, declaring a desire to arrive in early 2019. In fact, he first entered the UK in early 2020. His leave to remain was extended just weeks before the homicide. The DHR has established that Miles did not declare his offending history when applying for leave to enter the UK. He therefore committed a criminal offence, but one which the Crown Prosecution Service did not consider to be in the public interest to pursue, given that Miles was charged with murder.

8. The DHR Panel and Safer Sandwell Partnership Police and Crime Board (SSPPCB), when reviewing this report, expressed disappointment that the agencies responsible for overseeing and assessing Miles's entry into the UK, failed to identify that his offending history meant that Part 9, Paragraph 320 (2) of the Immigration Rules, which provide mandatory grounds for refusal, should have applied. (Grounds for refusal are included in the KLOE above). Miles should never have been allowed to enter the UK. It is impossible to say whether Angela would have continued her relationship with Miles had he been refused entry. She may have chosen to return to Jamaica, and would have remained at risk, but her commitment to her son Anton makes this possibility seem unlikely. A correct application of the law could have had the effect of increasing Angela's safety.

9. The SSPPCB will ensure that this learning point is shared with the Home Office and Border Force.

10. The DHR was unable to establish whether Angela knew anything about the nature and extent of any domestic abuse between Miles and previous partners or whether Miles disclosed his criminal history in the USA to his wife. Police in the West Midlands had little contact with either party in any relevant context. There were no reported incidents of domestic abuse between Angela and Miles, although the DHR was fully aware that an absence of reports to police does not indicate that domestic abuse is absent, and that many victims suffer multiple incidents before feeling able to report them. The DHR tried therefore to identify any social factors that could have alerted professionals to risk.

11. Both Angela and Miles suffered from diabetes, and both tended to be non-concordant with medical advice and did not attend some appointments relating to diabetes and linked health conditions. Angela and Miles had Type II diabetes mellitus, and Angela was particularly reluctant to change her lifestyle and diet and both Angela and Miles were resistant to taking insulin.

12. The DHR was mindful of research and evidence into the impact that poorly controlled diabetes and fluctuating glucose levels (both high and low) can have on mood, effecting self-control, causing feelings of anger, anxiety, or depression. This awareness was reflected in the Terms of Reference agency specific questions to health agencies. In the light of the available evidence from chronologies, the DHR concluded that whilst on occasion, both Miles and Angela disclosed to health professionals low mood and anxiety, the presence of other contributory factors that could also lead to low mood did not allow the Review to draw any firm conclusions concerning any impact of diabetes in this case.

13. The family dynamic in Angela's home was affected by the arrival of Angela's husband, Miles. An Approved Mental Health Practitioner (AMHP) carried out a mental health assessment of Anton in the autumn of 2020 that will be described in the chronology and analysis, which revealed some of the underlying tensions. Anton stated he could not remain in the family home and wanted to leave. Police attended a domestic incident in the autumn of 2020 between Anton and the family (described in the chronology and analysis). Anton moved out of the family home in early 2021 leaving Angela and Miles on their own.

14. Miles and Angela's relationship was not without some signs of difficulties. The Police investigation uncovered evidence that by summer 2021, Angela and Miles exchanged text messages and videos in which Angela spoke of 'needing to review' their relationship and potentially breaking up. The chronology and analysis will describe that in the autumn of 2021, Angela confided to a professional, her GP, that her husband was jealous and controlling. The situation appears to have deteriorated to the extent that according to the police investigation, Angela sent a SMS message to her closest friend in 2022 saying she was '*scared to be in the same house as Miles*.' During the trial it emerged Angela had demanded Miles leave the home during this period, but she relented, and he returned.

15. Miles applied for leave to remain in the UK as a dependent spouse in 2022 and it was granted until 2025. Angela is likely to have been placed under additional pressure because any separation or divorce could affect Miles and could have led to the Home Office curtailing his leave to remain.[1]

16. Angela went on a three-day mini-break holiday abroad with her closest friend, immediately before the homicide. Apparently, Miles was not happy about this. Upon her return, Miles picked her up from her friend's home at 19:30 and at around 22:45 an argument occurred during which Miles stabbed Angela. Miles fled the scene but was tracked down by Police and arrested.

17. In 2023, Miles pleaded guilty to murder and was sentenced to life imprisonment with a minimum term of 15 years.

[1] **Home Office Cancellation and Curtailment of Permission (October 2021)**

14 Chronology

1. The period under Review was during the COVID pandemic. The few incidents featuring in this chronology will be prefaced with a description of any COVID restrictions in place.

2. The DHR found there was very little relevant agency contact in this case. Miles and Angela were registered at the same GP and many of their contacts related to diabetes or other linked health conditions.

3. **(Pre-pandemic)** In early 2020 Police were called to Angela's home after she had been subject to a common assault, a push in the chest, from her neighbour, who was objecting to Anton's insistence upon playing his music loudly. The neighbour had threatened criminal damage to Anton's car. Angela chose not to pursue any complaint against the neighbour.

4. **(Post first lockdown, but before 22nd September 2020 when a renewed instruction to work from home, where possible, was announced. Home working had remained very widespread)** In early September, several months after Miles started to live with Angela and Anton, his care co-ordinator asked that an Approved Mental Health Practitioner (AMHP) assess Anton, after a deterioration in his mental health apparently because of not being able to go into work during the pandemic. This assessment was conducted face to face, which was particularly good practice, because although Department of Health Guidance during COVID[2] had apparently allowed assessments that could lead to 'sectioning' under sec. 2 Mental Health Act to be done remotely, the Mental Health Team of Sandwell MBC Adult Social Care, unlike many other Trusts, had chosen not to use remote assessments.

5. Angela was identified as Anton's nearest relative[3] and it was also good practice that she was spoken to. Angela had described a change in the family dynamic due to her new partner, Miles, living with them. She explained that Anton had become argumentative and aggressive with family and neighbours when he '*did not get his own way'*. For his part, Anton stated his family '*were being nasty to him*' and '*trying to drive him out*' which was assessed as indicative of paranoia. The team assessing him, which included a consultant who knew Anton, did not consider he met the threshold for sectioning but recognised a meeting to discuss assisting Anton to find alternative supported

[2] Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic 19 May 2020, Version 2

[3] Section 26 of the Mental Health Act 1983 (MHA) sets out who will be the nearest relative. The list is in strict order and the person who is highest on the list is considered the nearest relative. The list: 1. Husband, wife civil partner. 2.Son or daughter 3. Father or mother. The nearest relative should be consulted if consideration is being given to sectioning an adult under section 2 of the MHA.

accommodation would be useful. It is unclear how instrumental BCHFT were in finding Anton alternative housing, but by early 2021 he had moved out of Angela's home. The analysis will consider whether there was sufficient enquiry made at this assessment to understand any risk of domestic abuse to any person in the household.

6. **(Face to face encounter)** In autumn 2020, Police attended a dispute between Anton and Angela where Anton claimed he owned the home and he wanted Angela to move out. Anton had locked himself in the bathroom. Angela explained to Police Anton's mental health diagnosis, and they completed a Domestic Abuse Risk Assessment (DARA) that was graded as standard risk requiring no further action. There was no mention of Miles being present and the dispute seemed to between mother and son. Anton left to stay with a friend.

7. **(Phone contact)** Two days later, Anton contact Housing Floating Support claiming he had been seeking housing for three years and now his parents had given him 5 days to move out. It is assumed he was referring to Angela, but also Miles.

8. **(Telephone consultation)** In the autumn of 2021, Angela made a call to GP1 at her GP Practice. She chose to make a detailed disclosure concerning Miles's mental health and her health and domestic circumstances. She described disturbed sleep, and problems with attention affecting her concentration. She said Miles was prone to angry outbursts and experienced headaches. He was not sleeping and could be tearful. Angela was clear that for the two years of her marriage there had been marital issues and that Miles had always been jealous and controlling. Angela described Miles pacing around whilst making statements like '*you'll be responsible when I'm gone'*. The GP identified and asked about suicidal ideation and self-harm risk but concluded there was no history in this regard. Angela identified Miles's mother had recently died as had the mother of Miles's youngest children in Jamaica. Angela asked GP1 to speak directly to Miles, which he agreed to do, within the confines of patient confidentiality. He suggested to Angela she should self-refer to Sandwell Health Minds, a provider of talking therapies.

9. The same day GP1 spoke to Miles who disclosed anxiety and depression in part due to the social stressors Angela had identified. Miles stated his main concern was feeling disrespected by his wife who he claimed did not communicate with him or understand him as a husband. GP1 in Miles' notes recorded; *'DIAGNOSIS: marital problems. Plan-discussed options agreed to contact RELATE'*.

10. This encounter was the only relevant opportunity any professional had to offer appropriate support to Angela in relation to domestic abuse. GP1's interpretation of Angela's disclosure and his awareness of the best practice in these circumstances will be addressed below in the analysis.

15 Overview

1. In the absence of the insights that could have been gained from family and friend engagement with the DHR and an apparent lack of relevant contact with agencies, it is challenging to draw any firm conclusions concerning the nature of the relationship between Miles and Angela or opportunities to provide either party with support.

2. The DHR was guided by the NICE Quality Framework from 2016 as well as Domestic Abuse Act 2021 Statutory Guidance which, although not yet implemented at the time under review, represented a re-statement of best practice which should have already been in place. The guidance states in relation to Health professionals; '*There is a need for all frontline staff in public services to be trained to make enquiries into domestic abuse to ensure they are Making Every Contact Count. To provide the best support to victims of domestic abuse, it is essential that healthcare staff have the tools and confidence required to identify potential victims, sensitively, intervene at an early stage where possible, and refer on as appropriate. It is critical that all health professionals understand the need to enquire about domestic abuse, and how to do this safely, if they are concerned that a patient may be experiencing or perpetrating it.'*[4]

3. The Pathfinder Survivor Toolkit (June 2020)[5] was the result of a three-year national pilot project and collaboration between Standing Together against Domestic Abuse, Safe Lives and Identification and Referral to Improve Safety Interventions (IRISi) and others aiming to create a comprehensive and sustainable model responding to domestic abuse across the health economy. Its recommendations concerning enquiry and disclosure and data collection, monitoring, analysis, and practice improvement[6] informed the DHR's approach to addressing some of the shortcomings identified during the review.

4. The DHR was aware of the Pathfinder recommendation that '*IRIS should be rolled out in every GP surgery across the UK'.* Identification and Referral to Improve Safety (IRIS) is the pathway for Primary Care staff to obtain domestic abuse training and providing advocacy and support for patients. This makes a thematic review of the effectiveness of IRIS in Sandwell particularly apposite. This is a process commenced by partners during the DHR and one that will continue.

5. It is important not to fall prey to hindsight bias and invest a single missed opportunity with more resonance than it deserves. However, the Black Country ICB, both in their IMR and their comments on the DHR panel, saw Angela's engagement with her GP as emblematic of their already identified

[4] **Domestic Abuse Act 2021 Statutory Guidance page 93 paragraph 288**
[5] **https://communications.safelivesresearch.org.uk/Pathfinder%20Toolkit_Final.pdf**
[6] **Pathfinder Survivor Toolkit Chapter 9 Enquiry & disclosure and Chapter 12 data collection, monitoring, analysis, and practice improvement**

concerns. They were open and honest in relation to declining engagement of GPs in Sandwell with many aspects of IRIS, the pathway for Primary Care staff to obtain domestic abuse training and providing advocacy and support for patients. The ICB's concerns related to take up of IRIS training and re-training and, importantly, declining numbers of referrals made across Sandwell to IRIS.

6. Black Country Women's Aid, delivery partners for IRIS across the Boroughs that make up the Black Country, expressed similar concerns about GP engagement with IRIS across Sandwell. They contrasted this with an adjacent Local Authority area, where GPs' commitment to IRIS was demonstrably greater. Given that IRIS is an evidence-based nationally respected programme, this DHR will analyse available evidence to identify both solutions to local issues but also identify whether the nationally mandated programme has sufficient flexibility to allow local delivery partners to address cultural attitudes and beliefs of not only patients, but the health professionals being asked to make these crucial and sensitive enquiries of their patients.

16 Analysis

16.1 'Asking the Question' and Making Every Contact Count

1. The ICB IMR author engaged directly with GP1 to understand the nature of the contact with Angela in the autumn of 2021. The panel acknowledged Angela's willingness to disclose her problems and seek help from GP1 suggested a positive professional/patient relationship.

2. At the start of the COVID pandemic the need to move most GP consultations to phone contacts, during which domestic abuse may be identified or disclosed, was recognised to pose a serious risk in relation to ensuring a safe environment for the patient. IRIS published guidance[7] in April 2020 that was shared by the ICB with GPs in Sandwell. IRIS and the Department of Health anticipated that the national lockdowns would be accompanied by both heightened risk of domestic abuse and increasing difficulty for victims to access support. Even during the strictest periods of lockdown, if a patient was at high risk from domestic abuse, a face-to-face private consultation was an option open to GPs.

3. The IRIS guidance advised GPs to 'ask' and identify whether the conversation was safe and 'risk assess' to identify whether immediate protection was required and then to 'refer and signpost' to IRIS or other support.

4. Angela's specific disclosure, that Miles was '*jealous and controlling and prone to angry outbursts*', should have prompted a risk assessment before the consultation went any further because GP1

[7] **IRIS (April 2020) Guidance for General Practice**

should have been contemplating direct questions around Angela's experience of domestic abuse. In the light of this initial disclosure, acceding to her request to '*speak to*' Miles, a potential perpetrator, without a careful exploration of the exact nature of the abuse, was fraught with difficulties and risk to Angela. The GP would inevitably have to disclose to Miles that his wife had expressed concerns about his wellbeing which often would be seen by an abuser as both a challenge, and a justification for potentially more severe abuse or more comprehensive control.

5. The GP's apparent inability to identify domestic abuse in these circumstances and the conclusion, after hearing Miles's perspective, that this was a situation that could be resolved by counselling, suggests a lack of broader understanding of the nature of domestic abuse. Relationship counselling is not appropriate in a situation where there is domestic abuse, since it could allow a coercive controller to set the narrative and could put the victim at risk of both further emotional and physical abuse. Even if direct questions had been asked and Angela had denied she was experiencing domestic abuse, she should have been offered a referral to the IRIS advocate educator or been advised how to access that domestic abuse support at whichever point she chose. GP1 had undertaken IRIS training when the surgery signed up for IRIS in 2015 but was not present for the surgery's refresher training in 2019. For various reasons the practice had cancelled three subsequent scheduled re-training sessions.

6. IRIS training in 2023 includes a far greater emphasis upon coercive and controlling behaviours reflected in both the enactment of the criminal offence and its inclusion in the new statutory definition of domestic abuse in the Domestic Abuse Act 2021.

7. The ICB Designated Nurse for Adult Safeguarding who conducted GP training on IRIS in 2015 (and remains one of the clinical leads for IRIS) was clear that emotional abuse and controlling behaviours were at the heart of IRIS training in that period. In 2015 the emphasis upon emotional abuse was primarily to counteract the commonly held misapprehension amongst professionals (and the public), that domestic abuse always involved physical assault. It was around this period that many agencies moved away from the exclusionary term domestic violence and referred to domestic violence and abuse, or simply domestic abuse.

8. GP1 recollected in conversation with the IMR author that Angela had, when she described Miles's attitudes and behaviours, referred to him as a '*typical Jamaican man'*. This apparent stereotyping of Miles's abusive behaviours, particularly when used by a woman who was herself of Jamaican origin, may have reinforced GP's unconscious bias, allowing him to excuse or minimise them. Miles's subsequent responses could then be potentially seen as reflective of his misplaced sense of entitlement, but one the GP possibly felt disempowered to challenge with either party, because of

their shared ethnic origin. Stereotypical attitudes expressed about a community or ethnic group, by an individual identifying as part of that group, should not be given undue credence and appropriate challenge is a vital part of good practice, even where it is likely to be a difficult conversation. Practitioners need to be aware and sensitive to support genuine cultural identity, whilst motivating perpetrators to choose to change dangerous and abusive behaviours and be clear that they are unacceptable to society and often unlawful.

9. Professionals must be mindful that we all have unconscious bias, based on our upbringing, experiences in life, and beliefs. The unconscious brain deploys these biases to interpret information, leaving the conscious brain to deal with new or novel events. Without this awareness, we risk normalising or trivialising behaviours when they conform to our own stereotypes. Professionals need to learn how to actively guard against this, treating every encounter as an opportunity to discover the individual's lived experience, unencumbered as far as possible by bias or preconceived ideas or judgements.

10. That this consultation proved to be the only 'window of opportunity' to help Angela recognise she was the victim of domestic abuse and provide her with support, makes this missed opportunity particularly resonant.

11. If the GP did not identify that Angela was experiencing domestic abuse and misguidedly believed counselling was an appropriate solution, then this was compounded in many respects when Angela was encouraged by the GP to self-refer to Healthy Minds.

12. When faced with victims of domestic abuse who disclose that they are feeling anxious or have low mood, there is a tendency to 'medicalise' their experience of trauma as a mental health concern. Many victims of domestic abuse need support and understanding with general wellbeing, rather than being guided to a mental health pathway, but the provision of appropriate support is often lacking.

13. In 2022, the Domestic Abuse Commissioner and Women's Aid supported a group of Domestic Abuse Survivors to set up a National Domestic Abuse Survivors Group (DASG) 24/7 chat line, where survivors of domestic abuse offer pathways to counselling, self-care, and healing, to address trauma as well as practical advice to help survivors navigate the criminal and family courts.

14. The DHR concluded that any support for survivors that is trauma-informed and able to help survivors recognise for themselves the impact of abuse is positive. It was felt that the Safer Sandwell Partnership should promote DASG to their local partner agencies and identify and promote any local wellbeing support, which is not primarily focused upon mental ill health, that could meet the needs of domestic abuse survivors.

(**Recommendation five**)

15. The ICB IMR author was clear that GP1 and their GP partner in the practice were both committed to learn from this DHR and improve their safeguarding practice. Since Angela's death, the practice has received IRIS refresher training and an individual learning session with the Designated Adult Safeguarding Nurse. The IRIS advocate educator will also work closely with the Practice team.

16. The practice that Angela and Miles were registered with has a patient list of approximately 5,000. Figures from BCWA on referrals made by that practice revealed that the practice had only made one domestic abuse referral in the last two years. It is hard to avoid the conclusion that this IRIS trained practice had failed to embed their IRIS training and must not be 'asking the question' to identify when their patients are experiencing domestic abuse. This currently can only be surmised, based upon the figures provided to the ICB by BCWA of referrals made.

17. As GP electronic patient records (Systmone and EMIS) present currently, recording in an appropriate area of the safeguarding record that direct questions were asked and patient responses and coding DA appropriately, is the responsibility of the GP and their administrative team. They are advised on how to use these systems effectively at GPs' forums but may not yet fully appreciate the benefit of maximising their ability to monitor and audit safeguarding practice in relation to domestic abuse.

18. Both electronic patient records systems used have the capacity to improve auditing with little or no need for modifications. There is however little consistency in this recording across GP practices in Sandwell. At previous Sandwell GP Forums, GPs and practice managers were encouraged to achieve greater uniformity by promoting use of the RCGP guideline recommended read code – 'History of Domestic Abuse'. GPs have been encouraged to use the drop-down alerts for domestic abuse which are seen as best practice by CQC.

19. There are no available automatic prompts on GP systems to remind professionals to ask the question when a patient presents with health indicators that are suggestive of possible domestic abuse. This is a shortcoming that will be addressed by the ICB's IT team, and any appropriate modifications will be shared with Sandwell practices.

(**Recommendation two action 2.1)**

20. A GP practice Safeguarding lead should be able to interrogate their patient record IT systems to identify how frequently each trained member of staff 'asks the question'. This facility would be the starting point for demonstrating best practice, since effective enquiry will not always lead to a GP initiated referral to IRIS AEs. Some patients may prefer to initiate their own referral at a later stage. (Upon receipt of such a referral the advocate educator will establish whether the referrer has been

advised to make contact by their GP practice and therefore the effectiveness of individual practices could be demonstrated retrospectively through audits.)

21. If a GP or trained staff member initiated an IRIS referral, the practice could elect to use the read code 'Referral to domestic violence advocate' facilitating auditing of referral numbers.

22. It was the view of the DHR that the ICB should re-emphasise and promote again the available capacity in current electronic patient record systems. The goal should be to achieve a far higher degree of uniformity in the auditing practice of Sandwell GP practices. If IRIS is to be fully effective, partners in the commissioning and delivery of IRIS need to identify data that explains, or at least sheds light, on current referral rates to IRIS.

(Recommendation two actions 2.1, 2.2)

16.2 Sandwell GPs and IRIS

1. This DHR starts from the premise, restated in the Pathfinder Survivor toolkit, that; '*Healthcare professionals have a unique window of opportunity to respond to survivors of domestic abuse. Many survivors who would not feel comfortable or able to disclose abuse to the police will attend healthcare appointments and ED. We know from domestic homicide reviews that in some cases health professionals will be the only statutory service in contact with both the survivor and perpetrator. For this reason, it is imperative that health professionals know how to enquire about domestic abuse safely, and to feel confident that it is a legitimate and important part of their role to do so.'*

2. Were Sandwell's IRIS programme operating effectively, it would be reasonable to consider this one example of ineffective practice as an exception, best addressed through remedial work with that practice. The DHR was heartened by both the IRIS commissioners (the ICB) and IRIS providers (BCWA) determination to acknowledge this episode as being symptomatic of a wider, previously identified problem. The DHR saw this as an opportunity to identify why engagement with IRIS in Sandwell is patchy and referral rates are low, in comparison with IRIS in neighbouring Local Authority areas. Discussions were held to analyse these concerns at a separate panel, which was attended by the BCWA Chief Executive.

3. In any consideration of the effectiveness of Sandwell GPs and staff in identifying and safely asking about domestic abuse, it is important to understand the demographic of the population that make up their patient lists. The 2019 Index of Multiple Deprivation ranks Sandwell as the eighth most deprived English local authority, placing it among the most deprived 5% of districts in the country.

Within the borough there are significant levels of deprivation: more than half of Sandwell's 186 neighbourhoods are in the most deprived 20% in England.

4. The population of Sandwell is 345,594 with 23.8% aged 0-17, 59.9% aged 18-64 and 14.6% aged 65+. This is above the England average (20.2%) for the percentage of people aged 0-17 years old and below the England average (17.4%) for people aged 65 years old and over. 40% of the population are from Black, Asian, minority ethnic groups. Groups include people from Bangladesh, China, Gambia, India, Ireland, Italy, Jamaica, Nigeria, Pakistan, Philippines, Poland, Somalia, Spain, Zimbabwe.

5. The impact of poverty and deprivation upon victims of domestic abuse is well researched and a study carried out in the West Midlands in 2018[8] pointed out its gendered nature; *'poverty may exacerbate domestic abuse and violence by increasing or prolonging women's exposure to it and by reducing their ability to flee…for half of domestic violence victims living with their abuser, financial abuse prevents them from leaving the relationship.'*[9]

6. There is evidence that some communities in deprived areas will be at substantial risk of social exclusion; they may be unsure how to access or be excluded from access to services. Migrant women, for example, may have no recourse to public funds and be economically very vulnerable to domestic abuse. Cultural values, beliefs and pressures may make patients from some communities less likely to express their feelings about their experience of abuse or seek support from outside their community.

7. It is beyond the remit or capacity of the DHR to identify how far these factors impact upon the willingness of patients in Sandwell to discuss or disclose their experiences of domestic abuse to GPs or staff. However, the DHR can seek to ensure that structures and processes are in place in Sandwell that ensure GP practices adopt culturally sensitive best practice in relation to DA. This should include honest and open reflection by professionals concerning barriers to disclosure which may include a failure to create a safe and empathetic environment. The gender of the professional attempting to make safe and empathetic enquiry of patients may also be a factor; willingness to talk to a professional may be enhanced by an ability to offer the patient a choice.

8. Since every individual has unconscious bias, it is important to recognise that frontline professionals addressing domestic abuse may be influenced unconsciously by their values and beliefs or cultural attitudes. Professionals need to be mindful of achieving effective cross-cultural working with victims and perpetrators of domestic abuse. They need to be confident to interrogate the cultural biases

[8] The Female Face of Poverty: examining the cause and consequences of economic deprivation for women. (Women's budget group) https://wbg.org.uk/analysis/the-female-face-of-poverty/

[9] Women's Aid (2015) Unequal, trapped, controlled: women's experience of financial abuse.

and barriers that feed into a patient's responses, but also their own. The DHR recognised that in a multi-cultural community such as Sandwell, with many practitioners drawn from those communities this awareness is essential to effective support.

9. The DHR was offered substantial evidence by the ICB, who commission BCWA to provide IRIS training, (supported by the Designated Nurse for Adult Safeguarding), that current IRIS training does place considerable emphasis upon cross-cultural working.

10. The DHR recognised that cross cultural working is woven throughout the training. A diversity and inclusion statement at the beginning of the IRIS training manuals, reminds trainers that it is important for local sites to tailor the training to ensure it considers the local demographics of their patient population and that intersectionality is woven throughout all content. Teaching includes a 'DVA enquiry, responding safety and risk' section which stresses the need to be aware of cultural issues. Current training covers understanding the barriers those from ethnic minority groups face when disclosing DVA and accessing support and addresses how clinicians may contribute to barriers and how they can work to mitigate that impact. A video is used which illustrates the unconscious barriers a Black couple may face accessing support and reiterates that anyone can be affected by DVA.

11. Last year IRISi held a number of free 'through the lens' workshops for IRIS teams, to upskill them when delivering the IRIS training. The subject of workshops included: Black women experiencing domestic violence and abuse (DVA), harmful practices for Black, Asian and minority ethnic women. They included considering health presentations of people of different race/ethnicity, barriers accessing support or to leaving abusive relationships for people from different cultures. There were specific sessions on harmful practices, female genital mutilation (FGM), forced marriage, honour-based violence (HBV). They sought to educate professionals to support these victims appropriately. The workshops covered the additional barriers to disclosure they may face, including unconscious bias, when seeking support or being asked about DVA. This included consideration of the medical power and control wheel, depicting the ways in which professionals can collude with perpetrator i.e., failing to response to a disclosure, acceptance of intimidation or abuse as normal within relationships.

12. The GP practice in this case is illustrative of the challenges faced by any agency trying to ensure best practice is adopted by their professionals. In the aftermath of intensive publicity or training on a theme, practice tends to improve, but these gains need to be protected. As new staff join an organisation or trained staff leave, if the themes are not repeated, practice often deteriorates or returns to previous levels. Agencies need to be conscious of professionals whose knowledge is

outdated and who have not taken an opportunity as in this case, to refresh that understanding. The panel was satisfied that BCWA and the ICB will ensure that refresher training for GPs in Sandwell, who may not have had recent training that emphasises this theme, will put particular emphasis on cultural barriers to accessing support and unconscious bias.

13. It is very possible that the diverse communities and differing cultural values of Sandwell's residents pose very specific challenges for GPs in relation to supporting domestic abuse victims. The DHR concluded that for IRIS to be effective in a local area demonstrating this wide diversity in its population and its professionals, local IRIS providers need to be allowed flexibility in the context of IRIS training, to place even greater emphasis upon cross-cultural working. The local IRISi lead assured the DHR that IRISi strongly encourage IRIS sites to tailor the IRIS training so that it is more relevant to each area. This would therefore allow learning from this DHR to inform local training. It was therefore agreed that the learning from this review can be shared in training and does not require a recommendation.

14. Sandwell & West Birmingham Clinical Commissioning Group (CCG), now replaced by the Black Country Integrated Care Board, were pioneers in bringing IRIS to their GP practices with the programme starting to roll out in 2015. (A neighbouring Local Authority area, by comparison, has only introduced IRIS in 2022.)

15. Sandwell has 49 GP practices across 8 Primary Care Networks. 44 of those are fully trained and two are partially trained, having completed the initial training, but not having completed the second session which is usually delivered by the IRIS advocate/educator (AE).

16. Once GP practices are trained, it is their responsibility to make referrals to the AE, ideally with the patient's consent. The model does however allow for a GP or trained member of staff to make a referral, noting consent has not been obtained, generally in cases that are perceived as high risk or where engagement has been hard to achieve.

17. GP practices have a broad responsibility to demonstrate the effectiveness of their safeguarding of adults and children to their commissioners, the ICB. This would include their engagement with IRIS. Whilst it is a relatively crude and imprecise measure of performance, both the ICB and BCWA cited to the DHR that referrals made was viewed as a measure of success.

18. During DHR panels, both the ICB (Sandwell Place) and Black Country Women's Aid representative, (the training providers and managers of IRIS in the Black Country) expressed concerns that after a positive start, Sandwell's GPs are not fully engaged with IRIS both in relation to the number of domestic abuse referrals made into IRIS educator advocates, but also the willingness to meet with their IRIS advocate educators and create positive working relationships.

19. The Sandwell GP referral rate reported to the DHR was:

Year	Q1	Q2	Q3	Q4	Total
2021/22	23	30	30	20	103
2022/23	18	17	14	23	72

20. IRIS conducted a rapid review of national referral rates in November 2020[10] and argued that although there was a dip in referrals in March 2020, by July 2020, they had regained previous levels. By August 2020, IRIS training being delivered online by AEs included specific guidance on how to identify and ask about domestic violence and abuse in a telephone consultation.

21. The Sandwell figures for 2021/2022, at least in Q1, may have been impacted by the reduced number of face-to-face consultations, however that would not wholly account for the lower figures for referrals in 2022/2023. Whilst COVID's continuing impact upon the frequency of face-to-face consultations may be partially an explanation, this worrying decline in referrals appears to be rooted in poor engagement with IRIS in Sandwell.

22. BCWA, service providers for IRIS across the Black Country, summarised their concerns relating to poor engagement with IRIS in Sandwell. They described situations where reception staff are not allowing AEs to access colleagues, or practice managers who apparently do not respond to repeated attempts of AEs to engage with their practice. Practices are not responding to offers of training or cancelling training at the last moment and then not actively seeking to rebook. This is a very worrying situation that is very likely to mean that patients in Sandwell experiencing domestic abuse will not be offered suitable support and follow up. Engagement with IRIS is unlikely to improve if GPs do not recognise the Pathfinder approach; '*Your relationship with the service you hope to refer patients on to is vital to the success of your response to domestic abuse*.'[11]

23. The DHR would encourage the ICB and BCWA AEs to 'target' practices that are non-compliant with best practice (as indicated by a lack of referrals or training) through direct emails to practice managers and partners reminding them of the vital need to meet their DA safeguarding responsibilities.

(Recommendation two action 2.4)

[10] **IRIS response to the COVID 19 Pandemic: rapid research**

[11] ***The Pathfinder Survivor Toolkit: Chapter 10 Page 103 Referral Pathways. Steps to ensuring a robust relationship. I quoted step 2.***

24. The ICB and BCWA agreed early during the review that IRIS in Sandwell needs to be reinvigorated. Sandwell GP practices should be given every opportunity to re-engage and rediscover an enthusiasm for IRIS, recreating what the Pathfinder project calls a '*shared vision for health's response to domestic abuse*' that was by all accounts evident when the service was introduced in 2015. It was therefore proposed, and it will be a recommendation of this report, that an ongoing local dialogue be developed between PCNs, GP practices and the ICB and BCWA to identify how frontline professionals feel about IRIS delivery, but also how they see their role and responsibilities in relation to victims of domestic abuse.

    (Recommendation one action 1.1)

25. The ICB held a forum for their GPs in July 2023 as part of this process where, after consultation with the Safer Sandwell Partnership, learning from the DHR in relation to GPs' engagement with DA support was shared in a letter from the DHR chair. (Attached below as Annex I). The Named GP, supported by IRIS AEs, emphasised the need for greater concentration upon the early identification of domestic abuse.

26. A performance culture in relation to domestic abuse enquiry and referrals needs to be fostered in Sandwell. Whilst it is not proposed that increased DA referrals should be considered as the only evidence of success, it would be a welcome sign of progress. It is hoped that more of Sandwell's GPs would come to consider high-quality domestic abuse support to patients to be as important as achieving performance targets currently so common in relation to other public health concerns and issues.

    The DHR would recommend The Black Country ICB and Sandwell Place Safeguarding Team should consider publishing referral rates quarterly, identifying high referring practices whilst also directly reaching out to any practice that has made no referrals offering support and advice. **(Recommendation two action 2.3)**

16.3 Data collection, monitoring, analysis, and practice improvement

1. The Pathfinder project stressed the need to gather data which can be analysed as a clear route to practice improvement. Among the recommendations that seem particularly relevant in this case are *'1/ Every health service should collect data on domestic abuse training attended by staff 2/Every health service should collect data on enquiry into domestic abuse to understand gaps in training'.*

2. To assist GPs to demonstrate engagement, the DHR would recommend the ICB IT team explore how GPs' electronic patient records (Systmone and EMIS being the most widely used) could be enhanced, possibly through drop down menus or markers, to ensure that when a patient presents with the

health indicators that could suggest DA, professionals are reminded to 'ask the question'. Consideration should also be given to how in practical ways the systems could be developed to ensure that when a professional has asked the question and/or made a referral, enhanced data could be gathered to assist practices in demonstrating best practice. The ICB should reiterate all their previous advice to practices on the use of electronic patient records to record monitor and audit the quality of safeguarding practice in relation to domestic abuse in conjunction with the new advice from their IT Team.

(Recommendation two action 2.1)

3. The Black Country ICB has circulated to GPs a revised Safeguarding Self-Assessment tool based around the Royal College of General Practitioners template (RCGP). It has been specifically adapted in the light of the DHR to include questions concerning referrals made to IRIS AEs, detailed figures on the number of staff trained on IRIS, and an account of when the practice has attended IRIS refresher training. It is recommended best practice that the self-assessment tool should be submitted to the ICB Sandwell Place annually, however because this cannot be mandated, compliance with this requirement is at best patchy. The processes recommend in relation to CQC inspections below could encourage greater compliance with this requirement.

(Recommendation three action 3.2)

16.4 Demonstrating Domestic Abuse best practice as part of Inspection and Auditing processes

4. The DHR considered the potential impact upon best practice in relation to domestic abuse of Care Quality Commission (CQC) inspections of GP practices. The CQC's Statement on Roles and responsibilities for Safeguarding Children and Adults[12] is non-specific and broad; '*checking that care providers have effective systems and processes in place to help keep children and adults safe from abuse and neglect.'* Similarly, the guide for CQC inspectors on safeguarding[13] identifies three key areas of enquiry; '*do staff know what abuse is, how to identify it, and when patients may be at risk of abuse or neglect? Do staff know how to act when they identify abuse or the potential for abuse? Does the organisation and its staff learn from safeguarding incidents or identified safeguarding risks?*'

5. The DHR considered it desirable that future CQC inspections should include in their assessment criteria, specific consideration of the DA trained staff's ability to identify and act appropriately in

[12] **https://www.cqc.org.uk/sites/default/files/20190621_SC121706_CQC_statement_February_2018_v3_0.pdf**
[13] **https://www.cqc.org.uk/sites/default/files/Brief_guide_Inspecting_Safeguarding_v2.pdf**

relation to domestic abuse. This should include identifying whether effective processes are in place to record 'asking the question' and making referrals to IRIS AEs.

6. The DHR recommends the SSP propose to the CQC adopting a specific domestic abuse key line of enquiry as part of the safeguarding element in inspections of GPs surgeries. The CQC has a duty to ensure that where a concern is raised around safeguarding, providers take remedial action. The concerns highlighted in this DHR are not unique and have been identified before in numerous DHRs across the region, as well as nationally.

(Recommendation three)

7. The CQC, as a matter of routine, inform the ICB of their inspection schedule for GP practices. The DHR will recommend that the Safeguarding Team of ICB should create a pre-inspection Domestic Abuse Safeguarding report for the CQC inspectors (if they are notified of the inspection). It should include a copy of the practice's most recent Safeguarding Self-Assessment (where one has been submitted), an annual total of DA referrals made to IRIS AEs (as well as the figures for two preceding years).

(Recommendation three action 3.1)

8. The DHR recognises that the ICB will need to provide some context in relation to referrals made, based on patient/staff ratios, since the number of referrals made by a large PCN will bear little relation to those of a single GP practice. The DHR felt that a 'league table' of referring practices would be divisive, however the ICB should consider sharing details of particularly effective practices in relation to DA support, so that other practices can learn from best practice.

(Recommendation two action 2.3)

9. The DHR recommends to the ICB Safeguarding team that they initiate a proportionate programme of annual, random 'dip samples' of the domestic abuse response of selected GP practices. To reduce the risk of resistance to the process, it may be advisable to seek 'volunteer' practices on the understanding that after the first year, practices would thereafter be selected at random. This audit should involve the Adult and Child Safeguarding practice leads, who would be asked to provide data in respect of 3-4 cases, demonstrating appropriate recording of disclosures, referrals to IRIS and any necessary referrals to Child or Adult Social Care, follow ups required, and outcomes. This opportunity to demonstrate best practice could be encouraged across the ICB with the inspection template serving as an in-house audit which would offer practices the opportunity to have available a portfolio of evidence.

(Recommendation three action 3.3)

16.5 Contractual terms for GP practices

1. The use of improved data from audits and closer scrutiny of IRIS implementation will provide a valuable tool to drive improvement across Sandwell's GP practices.

2. It could be argued that given the public health implications of domestic abuse, there is no reason that NHS England commissioners in future could not include adult and child safeguarding as a specific contract requirement in the NHS Standard Contract. It is instructive to consider the changes implemented for 2023/2024 around, for example, the Quality and Outcomes Framework (QOF) through which GP will receive funding based upon performance indicators relating to carrying out checks of patient cholesterol levels or face-to-face dementia reviews. Not for the first time a panel speculated whether GPs and staff would be more likely to 'ask the question' of patients were it a QOF with financial reward?

16.6 Mental Health and asking the question concerning Domestic Abuse in Mental Health Risk Assessments

1. Whilst the primary focus of the DHR has concerned the role of GPs in relation to safe enquiry concerning DA when patients present with health indicators suggestive of possible domestic abuse, the review was clear that an even stricter safeguarding responsibility in relation to DA is placed upon mental health professionals. NICE Guidelines[14] state 'Ensure *trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, **mental health**, children's, and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.'*

2. Historically mental health assessments encouraged practitioners to consider the social circumstances of a person, and this always included identifying risk to others, but are less explicit when seeking to identify risk from others – particularly from domestic abuse.

3. In the Pathfinder recommendations relating to routine enquiry are:

   '1/ Mental Health Trusts should ensure staff understand how experiences of domestic abuse contribute to current presentations of mental distress. 2/ Mental health Trusts should ensure domestic abuse questions are embedded into assessment documentation and in clinical audit.'

4. This DHR identified a single occasion, the AMHP assessment of the autumn of 2020, where the potential for domestic abuse was evident. Anton was clear (as was his mother) that he was not happy

[14] **NICE Public Health Guideline 50 (2014) recommendation 6 -ensure trained staff ask people about domestic violence and abuse.**

about Miles being part of the family and his statements were specific; he was stating his family were '*nasty to him*' him and trying to '*drive him out'*. The ASC IMR was unable to interview the AMHP who has since left, but the assessment does not contain any recorded evidence as to whether professional curiosity was shown in relation to the family dynamics and potential domestic abuse.

5. ASC's IMR author explained their Mental Health Threshold Assessment grid '*addresses consideration around risk, abuse or exploitation from other individuals or society'*. In their IMR ASC explained; '*There is no prescribed procedure relating to 'asking the question' in relation to DA when an AMHP is asked to initiate a Mental Health Act Assessment as there is a need to balance risk and appropriateness when conducting assessments.*'

6. The DHR would argue that whilst a section 2 Mental Health Assessment is a sensitive process, it is potentially a first encounter with a person requiring mental health support who could also be experiencing domestic abuse and therefore should include routine questioning as part of that process to comply with NICE guidance. AMHPs need to always consider that mental distress could have domestic abuse as one of its causes and this would be promoted by routine questioning.

7. Without this mindset, where the primary consideration of an assessment is to decide whether a person's mental health has reached the threshold for detention for assessment and possibly treatment, the risk is that a patient's claims about his family are seen as a manifestation of worsening mental health, rather than seen as a disclosure that a person has experienced abuse which may, in part, account for their worsening mental health.

8. If, as seems increasingly likely, Miles's relationship with Angela was characterised by controlling behaviours, then it is not unreasonable to surmise there could have been tensions and risks in Miles's relationship with Anton, who did not want him in the home. In the context of a controlling individual in the household, it is also not surprising Angela described to the AMHP Anton's arguments with 'the family' and neighbours but apparently made no mention of Miles. Miles was not present when the AMHP assessed Anton, so given the opportunity to speak in private, Anton may have responded to direct questions.

9. The Mental Health Act (MHA) Guidance[15] explains AMHPs are required to consider; *'all the circumstances of the case. In practice, that might include the history of the patient's mental disorder, the patient's mental disorder, the patient's present condition and the social, familial factors bearing on it*.' If Anton's clear disclosures did not prompt the AMHP to ask direct questions about the potential for domestic abuse by other adults in the house, including his mother's newly arrived

[15] **MHA guidance paragraph 8.32**

husband, then it could be argued the assessment grid needs to include far more specific domestic abuse prompts in line with the recommendations cited above.

10. Having apparently not been seen as a prompt for more professional curiosity, it is therefore unsurprising there is no evidence that Anton's disclosure was fed back to the Mental Healthcare coordinator, nor that the written assessment threshold grid was shared. The ASC IMR explained that AMHP assessments are reviewed during supervision with their Team Manager and '*considerations of domestic violence and abuse are reflectively discussed*'. If the assessment was supervised, there is no evidence that a manager recognised a possible missed opportunity.

11. ASC informed the DHR that the AMHP Supervision policy was being re-written and would include more specific guidance on domestic abuse. This could bring the AMHP process more in line with Pathfinder recommendations. The DHR would encourage ASC to determine whether this incident is reflective of AMHP practice in general or is unrepresentative of the level of awareness of domestic abuse demonstrated in AMHP assessments. To this end the DHR would recommend that Sandwell ASC review AMHP assessments and identify the frequency with which domestic abuse by or to a patient is identified and consider whether their assessment threshold grid should contain specific domestic abuse prompts.

    (Recommendation four)

17 Conclusions

1. The overriding theme of this DHR has been the importance of frontline professionals 'making every contact count'. It takes immense courage for victims of domestic abuse to make any disclosure to professionals or family and seek help and often this is only after unreported, prolonged abuse.

2. The apparent failure to take the single opportunity that presented itself to support Angela, to recognise herself as a victim of domestic abuse, is deeply regrettable. It is not possible to know whether, if Angela had spoken to an IRIS advocate educator, she would have been able to identify a path to safety and freedom from abuse but that could have been a potential outcome. It seems it was something she had actively considered in discussions with her best friend.

3. This missed opportunity has led to detailed and open reflection about the effectiveness of IRIS in Sandwell and the recommendations and actions stemming from them were drawn up in consultation with ICB Safeguarding team and BCWA.

4. The Pathfinder recommendations have been reflected in this DHR's recommendations, where appropriate.

18 Lessons to be Learnt

Key learning for GPs, DA trained practice staff and all MH teams

- Coercive and controlling behaviours and jealousy are almost always present in domestic abuse.
- You may only get one opportunity to support a victim of domestic abuse so you must make every contact count.
- Mental health professionals are expected to make routine enquiry in relation to domestic abuse.
- GPs and trained staff should be aware of the health indicators[16] that could indicate a patient is experiencing domestic abuse and 'should ask the question' when any of these are present.
- Ask direct questions about the extent and nature of the abuse and offer a referral to domestic abuse services. Don't avoid those difficult conversations. The 'HARK'[17] model may assist you in framing appropriate questions.
- Domestic abuse perpetrators will blame their victim for the abuse and always avoid any personal responsibility.
- Abusers will seek to manipulate your professional judgement to derail support to the victim.

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[16] Indicators will vary for adult and child survivors and perpetrators, however common conditions linked to survivors of domestic abuse are depression, anxiety, sleep and eating disorders, suicidal thoughts/plans or attempts, unexplained chronic gastrointestinal symptoms, adverse reproductive outcomes, including multiple unintended pregnancies or terminations, chronic unexplained pain, traumatic injury, particularly if repeated and with vague or implausible explanations and an intrusive 'other person' in consultations, including partner or spouse, parent, grandparent or an adult child.

National Institute for Health and Care Excellence (2016), Domestic violence and abuse

[17] Sohal H, Eldridge S, Feder G; The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. BMC Fam Pract. 2007 Aug 298:49

Humiliation: "In the last year, have you been humiliated or emotionally abused in other ways by your partner/family member?" "Does your partner/family member make you feel bad about yourself?" "Do you feel you can do nothing right?"

Afraid: "In the last year have you been afraid of your partner or ex-partner/family member?" "What does your partner/family member do that scares you?"

Rape: "In the last year have you been raped by your partner or forced to have any kind of sexual activity?" "Do you ever feel you have to have sex when you don't want to?" "Are you ever forced to do anything you are not comfortable with?"

Kick: "In the last year have you been physically hurt by your partner/family member?" "Does your partner/family member threaten to hurt you?"

It is not just about what questions you ask but also how you ask them. It is important that you are confident in your enquiry – being comfortable will send a message to the patient that this is not a shameful topic. So, ask the questions in your own words that feel comfortable for you.

Pathfinder Survivor Toolkit page 99

- Advising marriage guidance and counselling is never appropriate where we know or suspect there is domestic abuse.
- We **all** have unconscious bias and stereotypes and may allow them to influence our decisions. Always ask yourself 'do I understand this person and their lived experience?' There really is no such thing as a 'typical' person - we are all different and unique. Reflect on practice and challenge your judgements.
- Ensure everyone in your team knows appropriate responses and support that can be offered to a patient who is a perpetrator of domestic abuse.
- Is there an opportunity to improve domestic abuse support by engagement with IRIS or other DA support?
- Is your domestic abuse training up to date? You may be missing out on new guidance or best practice.
- Do you know the name of your domestic abuse advocate /educator? When did you last refer a patient to IRIS or discuss a concern with them?
- Your advocate/educator should be in regular touch with your GP practice and your Safeguarding lead, so if that isn't the case now, make contact.

19 Recommendations

Recommendation one: The DHR Recommends that the Black Country ICB (Sandwell Place) and BCWA open and maintain a regular dialogue with GP practices and PCNs to create a shared vision of how domestic abuse support is delivered in Sandwell. They should reflect on all barriers to disclosure, identifying and sharing best practice and find shared solutions to identified challenges in providing domestic abuse support using the IRIS model.						
Reference	**Action (SMART)**	**Lead Officer**	**Target date**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
1.1	The ICB (Sandwell Place) to use current Primary Care Safeguarding Leads Meetings to reinvigorate GP engagement with IRIS	Designated Nurses Child and Adult Safeguarding ICB Sandwell Place IRIS AEs	January 2024	1. That the ICB (Sandwell Place) can provide assurance to the SSP of regular discussion at GP forums of IRIS 2. That AEs make themselves known to GPs at each GP forum and identify recent learning/best practice		SSP provided with a summary of DA related discussions and topics at GP forums
1.2	That the ICB and BCWA panel members on reviews continue to encourage DHR, SAR and CPSR Chairs to release key learning that relates to DA support by primary and secondary care, as soon as possible	Designated Nurses Child and Adult Safeguarding ICB Sandwell Place BCWA IRIS AEs and managers		1. Early sharing of key learning that relates to how health professionals identify domestic abuse and provide pathways to support		Evidence provided to the SSP of how DA related updates are circulated to healthcare staff
1.3	That the ICB consider creating a short series of podcasts that BCWA could contribute to, which would be shared with practitioners, relating to any	Designated Nurses Child		1. Improvements in service delivery		Publication of podcasts on a suitable platform

	aspect of DA support that is identified as challenging for e.g. 'asking the right questions' and unconscious bias	and Adult Safeguarding ICB Sandwell Place BCWA IRIS AEs and managers				

Recommendation two: The Black Country ICB IT team and safeguarding leads should review appropriate data collection, monitoring, and analysis in relation to all aspects of domestic abuse support to allow a strategic assessment of the effectiveness of GP responses to domestic abuse and promote improvements						
Reference	**Action (SMART)**	**Lead Officer**	**Target date**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
2.1	Black Country ICB should seek to identify how currently used electronic patient records could be enhanced to allow both GP practices and the ICB to monitor the effectiveness of trained staff in identifying DA through direct questions, and making appropriate referrals	Black Country ICB Sandwell Place Child and Adult Designated Nurses	April 2024	That the ICB provides evidence: 1. That enhancements to electronic patient records have been identified. 2. GP practices and PCN have been offered guidance on their use. 3. Of improved data sets in relation to 'asking the question'	Safer Sandwell Partnership	GP practices being able to demonstrate with data that they are 'asking the question' when a patient presents with health indicators that suggest possible domestic abuse. Increased referrals to IRIS AEs

2.2	Black Country ICB and BCWA to identify and share with partners how referral rates of GP practices will be judged based on a ratio of trained staff to patient numbers and any other factor considered relevant to accurate data collection (i.e. disaggregated data on protected characteristics)	Black Country ICB Sandwell Place Child and Adult Designated Nurses BCWA Community Services manager	April 2024	That the ICB and BCWA could provide objective data on what a 'good' referral rate is for individual practices and Sandwell Place's GP practices and PCN as a whole		Report to the SSP on referral rated based on new improved data
2.3	ICB to publish quarterly a list of top performing practices with a short commentary from safeguarding leads on how this has been achieved	Black Country ICB Sandwell Place Child and Adult Designated Nurses	Feb 2024	Best practice is shared across practices and a desire to be seen as a top performing practice motivates professionals to ask the question		ICB able to share with the SSP the details of top performing practices
2.4	Black Country ICB and BCWA to identify in relation to DA Support, poor performing GP practices and make regular direct approaches both in person and email, to senior partners and practice managers to encourage better engagement with IRIS	Black Country ICB Sandwell Place Child and Adult Designated Nurses BCWA	Feb 2024	That all GP practices in Sandwell engage effectively with IRIS		ICB and BCWA able to evidence how engagement of underperforming practices has been improved

Recommendation three: The Black Country ICB should engage with the CQC to request that a thematic review of domestic abuse safeguarding responses form part of their inspection regime for GP practices and provide data to the CQC to facilitate this.						
Reference	**Action (SMART)**	**Lead Officer**	**Target date**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
3.1	The ICB should prepare a short performance summary of individual practices in relation to their identifying DA and making referrals, when they are notified of a CQC inspection.	ICB	Feb 2024	That GP practices expect to be asked by CQC inspectors to account for their DA support practice and have reliable evidence to demonstrate excellence. That GP practices are encouraged to see their performance in relation to safeguarding and identifying DA and providing pathways to support, to be as important as any other area of work	Safer Sandwell Partnership	CQC inspections
3.2	The ICB should promote the use of the Safeguarding Self-Assessment Tool as a valuable tool that practices can share with CQC to demonstrate their compliance with safeguarding requirements	ICB	Feb 2024	Improved engagement with safeguarding		All GP practices and PCNs submit annual safeguarding self-assessments
3.3	That the ICB Safeguarding team encourage 3-4 GP practices to undertake a voluntary audit of DA safeguarding practice. (This should with due warning, become a random audit)	ICB		Development of an appropriate audit process that could be shared with Safeguarding leads and could be used independently of the ICB		Safeguarding leads include evidence of auditing DA identification, referral pathways and outcomes in their Self-assessment returns

Recommendation four: Sandwell Adult Social Care Mental Health Team should review their performance, procedures and documentation and provide assurance to the SSP that AMHPs are carrying out routine questioning in relation to domestic abuse and that DA is adequately explored in supervisory review						
Reference	**Action (SMART)**	**Lead Officer**	**Target date**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
4.1	Sandwell Adult Social Care Mental Health Team should review AMHP assessments to establish whether they are identifying DA and pathways to support	ASC MH Team Operational Head		ASC MH Team to be able to provide assurance to the SSP that AMHPs in Sandwell are working in accordance with best practice as outlined in Pathfinder Survivor Kit		ASC MH Team able to provide evidence of the number of DA referrals arising from AMHP assessments
4.2	Sandwell Adult Social Care Mental Health Team should review current documentation used by AMHPs in their Mental Health assessments and ensure routine domestic abuse questions are embedded in their threshold grid in line with Pathfinder recommendations	ASC MH Team Operational Head	Feb 2024	That ASC AMHP documentation has routine questioning embedded in line with Pathfinder recommendations	Safer Sandwell Partnership	ASC MH Team able to provide copies of assessment tools to demonstrate compliance
4.3	Sandwell Adult Social Care Mental Health Team should ensure their revised Supervision Plan ensures clinical audit of domestic abuse risk that reflects Pathfinder guidance	ASC MH Team Operational Head	Feb 2024	Improved engagement with safeguarding		ASC MH Team able to provide a copy of the Supervision plan highlighting DA emphasis

Recommendation five: Survivors of domestic abuse in Sandwell should be able to access appropriate support services that can in the first instance address wellbeing to reduce the frequency with which they are direct towards mental health services as a response to their experience of trauma						
Reference	**Action (SMART)**	**Lead Officer**	**Target date**	**Desired outcome of the action**	**Monitoring arrangements**	**How will success be measured?**
5.1	The Safer Sandwell Partnership should promote awareness of the Domestic Abuse Survivors Group (DASG) with all relevant partner agencies and domestic abuse support groups	Domestic Abuse Team Manager Sandwell MBC	Feb 2024	Partner agencies to raise survivor's awareness of trauma informed wellbeing services when domestic abuse is disclosed	Safer Sandwell Partnership	Partner agencies are able to provide assurance to the Safer Sandwell Partnership that their agency is promoting DASG and trauma-informed wellbeing services
5.2	The Safer Sandwell Partnership should identify and promote wellbeing services in Sandwell which are trauma informed and recognise that domestic abuse survivors may not wish to be directed to Mental Health services to address wellbeing	Domestic Abuse Team Manager Sandwell MBC	Feb 2024	Partner agencies to raise survivor's awareness of trauma informed wellbeing services when domestic abuse is disclosed	Safer Sandwell Partnership	Partner agencies are able to provide assurance to the Safer Sandwell Partnership that their agency is promoting DASG and trauma-informed wellbeing services

20 Annex I

Making Every Contact Count- learning from a Sandwell Domestic Homicide Review (DHR)

The Safer Sandwell Partnership (SSP) is currently undertaking a DHR into the tragic murder of a Sandwell woman by her husband. The Black Country Integrated Care Board want to be sure that key messages from the Review are shared with you as early as possible and the SSP have agreed that as Chair, I should send out this short message to all Primary Care staff in Sandwell.

The victim and perpetrator were registered at the same GP practice and were seen regularly by GPs and nurses in relation to their health needs. The victim apparently had a trusting relationship with her GP and in the autumn of 2021 chose to disclose her concerns (COVID restrictions were in place, and this was a telephone consultation). She said for the 2 years of her marriage there had been marital problems, and her husband was 'prone to angry outbursts and was jealous and controlling'. She asked her GP to speak to him, which the GP agreed to do. The husband told the GP that his wife disrespected him and did not 'understand him as a husband.' He said he was anxious and depressed.

Key learning for all Primary Care staff from this DHR:

- Coercive and controlling behaviours and jealousy are almost always present in domestic abuse.
- You may only get one opportunity to support a victim of domestic abuse so you must make every contact count. Ask direct questions about the extent and nature of the abuse and offer a referral to IRIS. Don't avoid those difficult conversations.
- Domestic abuse perpetrators will blame their victim for the abuse and always avoid any personal responsibility. They will seek to manipulate your professional judgement.
- Advising marriage guidance and counselling is never appropriate where we know or suspect there is domestic abuse.
- We all have unconscious bias and stereotypes and may allow them to influence our decisions. Always ask yourself 'do I understand this person and their lived experience?' Cultural stereotypes are rarely helpful. There really is no such thing as a 'typical' person within any culture - we are all different and unique. Reflect on practice and challenge your judgements.
- Ensure everyone in your practice knows appropriate responses and support that can be offered to a patient who is a perpetrator of domestic abuse.
- Is your IRIS training up to date? - you may be missing out on new guidance or best practice.
- Do you know the name of your IRIS advocate /educator? When did you last refer a patient to IRIS or discuss a concern with them?
- Your IRIS educator should be in regular touch with your practice and your Safeguarding lead, so if that isn't the case now, make contact.

Thank you for taking the time to read this message.

If you want to discuss domestic abuse support at your practice, talk to your IRIS educator or the Adult or Child Safeguarding Leads at the ICB (Sandwell Place) - they want to help you to ensure your safeguarding practice is as excellent as every other aspect of your patient care.

Simon Hill

Independent Chair of the DHR