Heart of England NHS
NHS Foundation Trust

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This policy is applicable to services provided by Heartlands, Good Hope and Solihull Hospitals Divisions

Domestic Abuse Policy v2.0

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Purpose:	To set out the Trust approach for managing cases of domestic abuse
Responsible Directorate:	Nursing
Executive Sponsor:	Sam Foster, Chief Nurse
Document Author:	Lead Nurse for Safeguarding Adults and Domestic Abuse
Approved by:	Chief Executive's Group
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Related Controlled documents	Adult Safeguarding Policy Child Safeguarding Policy
Relevant External Standards/ Legislation	Care Act 2014 Children Act
Target Audience:	All staff dealing with Domestic Abuse and those involved in managing those who do.
Further information:	Lead Nurse for Safeguarding Adults and Domestic Abuse

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Version History:

Version No.	Date of Release	Document Author	Ratified by	Date Ratified
2.0	TBC	Wendy Badger:Consulted: Domestic Abuse Steering Group Safeguarding Adults Steering Group Safeguarding Children's Steering Group Minor Changes made	TBC	TBC

Summary of changes from last version:

Addition of Care Act and factors that might make domestic abuse cases reportable to adult safeguarding.

Addition of action for lone managers to assure themselves that a member of staff disclosing domestic abuse is ablt to keep children and vulnerablre adults safe.

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Flow chart for dealing with a disclosure

Domestic Abuse- what to do following a disclosure

Listen, believe, support

Provide a confidential / private space to talk with victim.

Give details of abuse charities / support services (see appendix 1)

Is the victim or their child(ren) in immediate danger?

NO

Make a safeguarding referral if:

Children in household (children's details on referral form) or Victim is an adult at risk who has care & support

Do not press the victim to leave perpetrator; this is their decision to make when the time is right for them.

Treat any physical or mental health problems & consider referral to support services ie RAID, Alcohol / drug liaison

YES

Instigate child / adult safeguarding procedures

Consider police involvement
Involve manager

Do not press the victim to leave perpetrator; this is their decision to make when the time is right for them.

Treat any physical or mental health problems & consider referral to support services ie RAID, Alcohol / drug liaison

Is the victim safe to go home?

Consider alternatives such as staying with family or friend or referral to Refuge / Police.

Discuss a safety plan (see page 29)

Offer the patient an appointment with specialist support worker in **The Purple Clinic**
(Book on ☎: Maternity ext. 42682 ☎: A&E 43263 / 44070)

Document accurately including details of perpetrator and any injuries

If patient consents, contact medical photography to document injuries **(☎ 43435)**

Consider the need to share information safely (see Caldicott guidelines if needed).

Statement of Principles

- We will prioritise the safety of victims and their children in every aspect of decision making and intervention. We understand that victims and their children are most at risk when they end a violent relationship or seek help and will work to protect them when they do.

- We understand that without effective intervention, domestic violence and abuse often escalate in severity. We will make every effort to reach and identify adult and child victims earlier.

- We will treat victims with respect and dignity. We will listen to them and believe their experiences of violence; take seriously their concerns and seek to understand and strengthen their safety strategies.

- We will seek to gain informed consent from victims where possible when there is intention to share information.

- We will respect confidentiality and privacy wherever possible and understand the increased risks associated with information sharing in the context of domestic violence and abuse.

- We will maximise choices for domestic violence and abuse victims and empower domestic violence and abuse victims to make informed choices about their lives wherever possible.

- We will actively work to develop competent services which are sensitive to the diverse range and needs of the individuals and communities we serve.

- We will send clear messages that domestic abuse perpetrators are accountable for their own behaviour and that victims are never to blame.

- We will work co-operatively with the range of services that victims need.

- We will recognise the importance of specialist independent domestic violence and abuse services in providing a voice for victims and children guiding us on safe practice.

Adapted from West Midlands Domestic Violence and Abuse Standards
September 2015

1 Introduction

This policy reflects local, national, strategic and operational guidance produced in response to the growing recognition of the detrimental effects that domestic abuse has on women, children and society as a whole. It demonstrates the principle that domestic abuse and violence is unacceptable behaviour and that everyone has a right to live free from fear and abuse. It recognises the need to share information and work in partnership with other agencies with greater experience of domestic abuse in order to reduce the risk of harm to victims. While there is recognition that this is a Trust wide issue there is also a need to initially concentrate resources on those areas where staff frequently have contact with women and children experiencing abuse.

HEFT endorses the government's view that domestic abuse is a fundamental breach of trust and human rights, and contravenes an individual's right to feel safe, both within their home and within a personal relationship.

HEFT recognises the serious adverse impacts that domestic abuse has on children who live in a violent abusive household, and the short and long term damage to their physical and mental health. Within this context HEFT recognises its responsibilities to safeguard and protect children.

HEFT recognises domestic abuse is not only an issue for service users, and that there is a need to address domestic abuse issues for staff (male or female) when they themselves may be current or past victims of domestic abuse, or are perpetrators of domestic abuse.

2 Scope

To staff in a permanent, temporary, voluntary or contractor role acting for or on behalf of HEFT. This policy applies to all Heart of England NHS Foundation Trust (HEFT) staff and applies equally

This policy details the principles and standards to effectively address domestic abuse. This policy is not only relevant to health professionals working directly with service users, but also to all staff working in HEFT. This is in recognition that everyone shares responsibility for safeguarding children and at risk adults with care and support needs irrespective of individual roles.

Midwives can also refer to separate guidance which is specific to their speciality.

3 Aims and Objectives

It is widely recognised that health services alone cannot effectively meet the needs of individuals experiencing domestic abuse, however HEFT is committed to ensuring that domestic abuse is recognised, and that the local community are provided with information and support to minimise risk. In support of this, HEFT will work together with our local partner agencies in Solihull and Birmingham, towards the reduction of domestic abuse and by working together a consistent and co-ordinated response will be developed.

- To inform staff of best practice when responding to domestic abuse to enable them to respond effectively to those who disclose that they are victims of domestic abuse or who staff suspect may be a victim.
- Improve safety and improve health by recognising domestic abuse is a serious crime which has an adverse impact upon the health of individuals, families and communities.
- Increase awareness and understanding of domestic abuse across HEFT and its impact upon those experiencing it.
- Optimise opportunities for disclosure of domestic abuse in a safe environment
- Identify and address any safeguarding issues for children.
- Raise awareness of additional issues which can impact upon the safety of victims of domestic abuse from black and minority ethnic communities.
- To be able to undertake a risk assessment of the domestic abuse situation and share information with other agencies appropriately.
- Staff training to include a process which will facilitate early identification of domestic abuse and to offer supportive and effective intervention to reduce the risk of harm by utilising identified care pathways
- Ensure that all departments are clear within their roles in tackling and responding to issues surrounding domestic abuse.
- Support government policy for the NHS in terms of domestic abuse and to ensure implementation of a safe, consistent and quality approach to domestic abuse across HEFT.
- Support local strategic partnership delivery plans for domestic abuse.
- Ensure that processes are in place to support actions plans developed following a domestic homicide review, serious case review or internal management review
- To encourage staff to treat individuals with respect and dignity and not be judgmental.

4 Identified Duties and Responsibilities

Chief Executive

The Chief Executive retains overall responsibility for the Trust's policies, however delegates operational responsibility for the development and implementation of this policy to the Chief Nurse

Chief Nurse

The Chief Nurse is responsible for the development and review and monitoring of this Policy. The Chief Nurse will delegate this operational responsibility to the Head Nurses

Head Nurses

Head Nurses are responsible for ensuring the implementation of the policy within their area of responsibility

Safeguarding Adults team

The Adult Safeguarding team is responsible for policy development, implementation and evaluation, working with the Head Nurse for Adult and Children Safeguarding to ensure that the Trusts meets its responsibility. The Adult Safeguarding team is responsible for developing a robust reporting process to the Safeguarding Adult Steering group.

Lead Nurses/Clinical Leads

The Lead Nurses/Clinical Leads are responsible for overseeing the implementation of this policy within their own clinical areas of responsibility

Senior Sisters/Charge Nurses/Senior District Nurses/Team Leaders

Senior Sisters/Charge Nurses/Senior District Nurses/Team Leaders are responsible for the local dissemination and implementation of this policy

All Clinical Staff

Must familiarise themselves with the contents of this policy and to understand and recognise domestic abuse. If a person does disclose any form of domestic abuse to them you must follow and adhere to the process, document in accordance to the guidance set out in this policy and complete an IR1 (incident report) form via the Trust Intranet system, and copy to the Matron for Safeguarding Adults

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Safeguarding Adults Steering Group Responsibilities

This policy is approved and ratified by the Safeguarding Adult Steering Group following Trust wide consultation. This group will have responsibility for the implementation and monitoring of the policy. The author will have responsibility for the development and review of this policy

5 Definitions

The Home Office (2013) defines domestic abuse as:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.
This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional
- controlling behaviour which is a range of acts designed to make a person subordinate and/or dependent by;

- isolating them from sources of support,
- exploiting their resources and capacities for personal gain,
- depriving them of the means needed for independence, resistance and escape and
- regulating their everyday behaviour.

- coercive behaviour- an act or a pattern of acts of;
  - assault
  - threats
  - humiliation and intimidation
  - or other abuse that is used to harm, punish, or frighten the victim.

It is acknowledged that domestic abuse can also manifest itself through the actions of immediate and extended family members with the perpetuation of unlawful activities such as forced marriage, so called 'honour crimes' and female genital mutilation. Extended family members may condone or even share in the pattern of abuse. However, domestic abuse is a crime and is neither morally nor socially acceptable whichever form it takes.

6 Procedure

Guidance from government departments and key voluntary agencies advocate a proactive approach to domestic abuse (DOH 2011) and evidence shows that direct questions get more positive results than vague queries. Research findings indicate that many survivors of domestic abuse wanted someone to ask them what was happening at home when in contact with a health professional. However, in all contact with clients who may have experienced domestic abuse it is vital that health care staff ask the question: 'Will my intervention leave this person and their children in greater safety or greater danger.?'

Training is being developed in order to ensure that practitioners continue to feel competent in adopting a proactive approach in addressing domestic abuse, identifying risk and understanding relevant care pathways.

6.1 Asking about Domestic Abuse

There are two main situations where questions about domestic abuse need to be asked:

a) Routine enquiry – sensitive routine questioning gives abused client's permission to speak about domestic abuse.

Within HEFT the following staff groups currently practice routine enquiry:

Midwives:	**Health Visitors**
Twice during antenatal appointments **Once post natal**	**New family encounter** **Birth visit**

Information about domestic abuse specialist services should be passed to all women who attend maternity services within Heart of England hospitals. An explanation should be made

to the women that this procedure is done routinely in order to ensure that the victim who chooses not to disclose does not feel threatened or endangered.

b) Selective enquiry- to be used by any health professional that has concerns and where it is safe to do so.

6.2 Guidance for health professionals

As health professionals supporting those who are experiencing domestic abuse, we have to be able to accept that sometimes patients will make decisions that we might find hard to understand. Overcoming our own frustrations and misperceptions forms an important part of providing support. Domestic abuse is always the responsibility of the perpetrator. Never blame the abused person – it's not their fault.

Your role in responding to domestic abuse should be limited to:

- Focusing on the victim's safety and that of any children in the household;
- Giving the victim information and referring them to relevant agencies;
- Making it easy for the person to talk about their experiences;
- Supporting and reassuring the person; and
- Being non-judgemental

You should never assume that someone else will take care of domestic abuse issues – you may be the victim's first and only contact.

It is not your role to encourage the victim to leave their partner, or to take any other particular course of action. This could lead to problems, including increased danger for the victim and the children.

Don't act as a caseworker for the person once you have referred him/her to sources of help.

Remember that there are domestic violence agencies that fulfil that role. Of course, you will still need to carry out your usual health duties and provide support that is appropriate to your role.

Practitioners should be aware of their own safety needs. Discussions with management and clinical supervision provide a framework for support.

Always be prepared to work in partnership with other organisations that have been set up to ensure a person's safety.

Always adhere to Trust policy and implement what you learn in training.

6.3 Aiding disclosure

Any interview should be undertaken in a suitable environment which does not include the perpetrator or any inappropriate person and respects the person's entitlement to privacy and dignity.

Never ask about possible abuse in the presence of the partner, the children or other family members.

Where the victim does not speak English it is essential that an interpreter is used to obtain a direct history from the victim. In no circumstances should a family member be asked to interpret.

It is important when asking the victim direct questions about their experience to do this sensitively and in a manner that is empathetic and supportive.

It is vital to ask direct questions rather than let an improbable explanation pass without saying anything or to hedge around the issue.

Listen carefully. The victim may talk around the subject before disclosing to you. Requests for help are often veiled and may 'hide' behind other things. Staff need to think about ways in which they could draw out further information.

Remind the victim of your position in terms of confidentiality; make your position with regards to child protection clear to the victim

Respect and validate what the victim tells you and remember that you may be the first person who has listened to them and taken them seriously.

6.4 Following disclosure

Please refer to the flow chart of this policy

6.5 Response and Risk Assessment

Once any immediate needs of the person have been met, e.g. treatment of physical injuries, referral for further treatment or specialist an 'assessment of safety' should be undertaken, such as:

- The victim's assessment of the danger they may be in
- The risk of self-harm or suicide threat by the abused victim.
- The availability of emotional and practical support.
- The increase of the violence in relation to the intensity, frequency and severity?
- Identification of children in the household. If this is the case, then the Solihull & Birmingham Inter Agency Child Protection Procedures must be adhered to.
- Is the victim an at risk adult with care and support needs? If so the Safeguarding Adult procedure of the local authority of where the victim resides must be followed, for further information see Pan West Midlands policy
- Is the victim subject to a forced marriage?

In considering the likely risks, the principal responsibility of the health professional is to support the victim in the decisions and choices they wish to make.

Health care professionals need also to take account of their own safety and that of their colleagues, and must minimise the risks that they may face from the perpetrator of domestic abuse.

6.6 Providing Information and Signposting.

It is not the responsibility of the health care professional to instruct someone experiencing domestic abuse on what action they should take. The person should be provided with information about where they can go for help (see appendix 2 for domestic abuse support services).

As of January 2016 there will be a weekly clinic ran by a Support Worker from Birmingham & Solihull Women's Aid held on a Wednesday morning in the Maternity Unit and in the afternoon in the Emergency Department at Heartlands site. This is open to both patients and staff.

6.7 Keeping records

Health records play an important role in responding to domestic abuse – and not just in a health setting. The records you keep can be used in:

- Criminal proceedings if a perpetrator faces charges;
- Obtaining an injunction or court order against a perpetrator;
- Immigration and deportation cases;
- Housing provision; and
- Civil procedures in family courts to assess the risks associated with granting an abusive parent contact with children.

Keep detailed, accurate and clear notes to indicate the harm that domestic abuse has caused. This can ultimately assist the person in living a safer life. Perpetrators will be more likely to be charged and sentenced.

6.8 Improving record keeping

- Always keep a detailed record of what you have discussed with the victim – even if suspicions of domestic abuse haven't led to disclosure. They might in the future.
- You don't need a patient's permission to record disclosure of domestic abuse or the findings of an examination. Make clear to the victim that you have a duty to keep a record of their disclosures and injuries as a duty of care.
- Keep records as detailed as possible (for example, 'patient states they were kicked twice in the stomach by partner/spouse rather than 'patient assaulted').
- Record the name of the perpetrator.
- Use the patient's own words (with quotation marks) rather than your own.

- Document injuries in as much detail as possible, and record if an injury and the persons explanation for it are consistent
- If possible, use drawings or body maps to show injuries. Photographs as proof of injuries should be taken by medical illustration
- Domestic abuse should never be recorded in hand-held notes, such as maternity notes or the children's personal health care record (red book held by the parent/carer)
- On our electronic records nothing about domestic abuse should be visible on the opening screen (which could be seen by a perpetrator or a member of staff who doesn't need to see information about the abuse).

6.9 Confidentiality and information sharing

It is vitally important that information on domestic abuse is kept confidential. Without confidentiality the person is less likely to talk about their experiences. Their physical safety can depend on it.
But it's important to understand – and to explain to the person who reveals that they are experiencing domestic abuse – that there are limits to confidentiality. For example, if there is reason to suspect children are at risk, safeguarding and protection should always take precedence over confidentiality.

6.10 Safe information sharing

- There will also be occasions when information about a domestic abuse case should be made available – either because it is required by law (if records are being used in a court case, for example) or to help support agencies tailor services to meet a family's needs (for advocacy or carrying out a risk assessment, for example)
- You will need to make an informed decision about whether you need to share information in a given situation. It's not always easy to balance confidentiality against the interests of disclosure. Never make a decision on your own
- Be particularly wary of situations in which confidentiality could accidentally be broken. For example, if a child who is staying at a refuge spends time in hospital and the abuser visits the child, you should take care that records that are on display do not include a contact address or any other information that could help a perpetrator track down people they have previously abused.
- In some instances, failure to share information can be as dangerous as breaking confidentiality inappropriately.
- Only ever consider giving information to reputable agencies – never to individuals making enquiries about a victim's circumstances.
- The only acceptable reason for sharing information is to increase a person's safety and that of the children. Even then only share information that is relevant.
- Adhere to the Trust's information sharing policy – advice and support can also be obtained from the information governance officer

6.11 Support for HEFT employees experiencing domestic abuse

If a member of staff discloses that they are victim of domestic abuse, the emphasis should be on supporting them in a calm and non-judgemental manner. This may include offering a

referral to Occupational Health services or signposting them to a specialist domestic abuse organisation.
It may be necessary to prevent or manage the access that the perpetrator has to Trust properties, or to offer the victim a temporary change in role whilst their situation and any associated risk is managed.

It is important to acknowledge that whilst the risk of staying in an abusive relationship may be very high, simply leaving the relationship does not guarantee that the abuse will stop. In fact, when the victim is a woman the period during which she is planning or making her exit, is often the most dangerous time for her and her children.

Once an employee has disclosed to their manager that they are experiencing domestic abuse, the manager should reassure them that they will keep this information confidential as far as possible.

However, confidentiality cannot be guaranteed where there are concerns that the impact of the domestic abuse is affecting the victim's ability to discharge their duties or where there are children in the household.

In these instances the manager should seek further advice from the safeguarding team who will work in partnership with the line manager, Human Resources and the staff member /victim to assess the risk and to plan on an individual basis the support required for the victim. The aim is to:

- Reduce the risk to the victim while in work
- Identify any work place risks to the victim or colleagues and support action to reduce the risk
- Identify and risk assess any impact on victim's ability to meet their role and responsibility as detailed in their job description
- Support the victim to practice safely or to return to practice through the development of an individualised programme which may include a competency based programme and assessment

If a member of staff is identified as a perpetrator of domestic abuse this will be dealt with by the Trust Human Resource and Safeguarding processes.

6.12 Risk Assessment

Staff in maternity and paediatric services should use the DVRIM tool to assist with risk assessment.

Managers in other areas should have a guided conversation to ensure the staff member can;

- Identify harm and abuse
- Know when and how to manage instances of harm and abuse

6.13 Referral to MARAC (Multi Agency Risk Assessment Conference)

The process for referral of very high risk cases into MARAC is shown in the appendices (maternity and paediatric services only)

6.14 Community colleagues

Police colleagues have a process for sharing notifications of domestic abuse in households with children. The process requires the police to seek consent for information sharing with health and social care from the family when they attend the incident.

The agencies will then participate in a Domestic Abuse Triage meeting to determine what level of risk they deem the incident to be using the DVRIM (Domestic Violence Risk Identification Matrix) Assessment Tool and which agency is required to lead intervention for the family. This process is led by the police. Domestic Abuse Triage Meetings are attended by safeguarding staff and relevant information is shared with Universal Services as agreed.

6.15 Domestic Homicide Reviews

Section 9 of the Domestic Violence, Crime and Victims Act 2004 introduced a statutory basis for local bodies to establish homicide reviews for victims of domestic violence. This provision creates an expectation that local areas should undertake a multi-agency review following a domestic violence homicide. HEFT will comply with this duty and will adhere to the guidance when participating in a review.

6.16 Human Trafficking

Human trafficking (or “trafficking in persons”) deprives its victims of their most basic human rights. Human trafficking is a complex and global crime that is not only limited to the developing world. Human trafficking means the recruitment, transport, harboring or receipt of persons by threat or use of force, deception, coercion or abuse of power used to lure the victims. Traffickers subject their victims to various forms of abuse, including sexual exploitation, forced labor, and domestic servitude, among others. Victims of trafficking usually suffer multiple victimizations and may seek services at local domestic violence and sexual assault programs.

Although domestic violence and human trafficking are different forms of victimizations, there are similarities and intersections between these types of violence. Women comprise the majority of victims of both domestic violence and human trafficking. Both batterers and traffickers use power and control to dominate their victims, and the range of tactics used by traffickers resembles that of domestic violence perpetrators. Common tactics used by traffickers include isolation, physical and emotional violence, sexual abuse and exploitation, financial abuse, threats to family members, use of children to manipulate and control their victims, withholding of food, sleep, and medical care, among others. However, domestic violence and human trafficking are not the same thing. Trafficking involves multiple actors and not a single abuser as in the case of domestic violence. Trafficking is an exploitation of female poverty and, generally, traffickers do not have an intimate relationship with the

victim. Also, levels of endangerment and legal remedies available are very different for trafficked women.

7. Further information about domestic abuse

7.1 Who might experience domestic abuse?

Although the majority of domestic abuse incidents relate to male perpetrators and female victims, this is not always the case. Domestic abuse also affects the lesbian, gay, bi-sexual and transgender community as well as male victims. Domestic abuse occurs among people of all income levels, ages and among people from all black, white and minority ethnic backgrounds. In terms of domestic abuse and ethnicity, British Crime Survey findings show little variation in the experience of inter-personal violence by ethnicity (Walby, 2004).

Domestic abuse is rarely a one-off incident, and should be seen as a pattern of abuse and controlling behaviour through which the abuser seeks power over their victim. Factors associated with being a victim of domestic violence include:

- Being female
- Having a learning disability
- Long-term illness or disability (women and men with a long-term illness or disability were almost twice as likely to experience domestic violence as others)
- Use of any recreational drug in the last year
- Marital status (married people had the lowest risk, while those who had previously been married had the highest risk)
- Age (women in younger age groups, in particular, in those aged 16–24 years are at greatest risk)

  (All of the above are: Home Office 2011.)
- Alcohol or drug consumption (partner assaults are four to eight times higher among people seeking treatment for substance-dependence) (Murphy and Ting 2010)
- Pregnancy (the greatest risk is for teenage mothers and during the period just after a woman has given birth (Harrykissoon et al. 2002)
- Being lesbian, gay, bisexual or transgender (Barter et al. 2009; Browne and Lim 2008; Home Office 2010b).

7.2 Male victims

Men are less likely to report domestic abuse to police than women, and more likely to consider it a trivial matter. (NICE 2014) Male victims of domestic abuse are also more likely to seek help from an online resource or through friends than speak to a healthcare professional. (Douglas and Hines 2011)

Please note: although anyone can be a victim of domestic violence regardless of their gender (including non-binary genders) and sexuality, the majority of victims are female and perpetrators male. Therefore, for ease of reference the female pronoun will be used for victim and the male pronoun for perpetrator throughout this policy. Where the information is gender-specific, that will be made clear.

7.3 Children and Young People

The issue of children living with domestic abuse is now recognised as a matter of concern in its own right by both government and key children's services agencies. The link between child abuse and domestic abuse is high with estimates ranging from 30% - 66% depending upon the study. However, it is recognised that 'children can suffer long-term damage from living in a household where domestic violence and abuse are taking place' DoH(2009). Therefore, whilst domestic abuse and child abuse do not always co-exist, it can be an important indicator of a child at risk of harm from either actual physical, sexual and/or emotional abuse or by exposure to abusive relationships.

The Adoption and Children Act 2002 extended the legal definition of harming children to include harm suffered by seeing or hearing ill treatment of others, especially in the home. Living with domestic abuse can adversely affect all of the five outcomes for children identified in Every Child Matters (2004). In addressing the needs of children living with domestic abuse, it is important to be aware that children develop their own coping strategies; however, it is known that adverse experiences in childhood can detrimentally affect cognitive, psychological, physical, social and educational development. This may warrant long term involvement of health services.

At least 750,000 children and young people are estimated to be exposed to domestic violence every year in England (DH 2002). Approximately 75% of those living in households where domestic violence occurs are exposed to actual incidents (Royal College of Psychiatrists 2004). Many will be traumatised by what they witness – whether it is the violence itself or the emotional and physical effects the behaviour has on someone else in the household (DH 2009). Domestic violence is also associated with an increased risk of abuse, deaths and serious injury for children and young people (DH 2009).

Domestic abuse often means that children live in an environment where there are high levels of physical punishment, misuse of power and authority and the generation of feelings of fear, anxiety and helplessness despite the best efforts of the non-abusive partner. Living with domestic abuse can cause distortion in children's perceptions of relationships, blame, cause and effect.

Recent studies suggest violence within adolescent relationships is increasing and there is increasing normalisation of violence within peer groups. (NSPCC,2011) Parents can also be the victims of abuse perpetrated by a child or adolescent, although the proportion affected in England is unknown (Kennair and Mellor 2007).

Domestic Abuse often begins or increases when a woman is pregnant. This presents an immediate need to safeguard the victim and the unborn child.

Risks in relation to carers need to be considered. Research identifies that the characteristics of the families where a serious case review was undertaken where domestic violence, mental ill-health, and drug and alcohol misuse. Frequently, more than one of these characteristics was present. Learning lessons from Research (OFSTED 2011).

The welfare of a child is paramount. In cases of suspected child abuse the duty of care that any health professional owes to a child or young person will take precedence over any obligation to the parent or adult carer. Living with or witnessing domestic abuse is now recognised as a source of significant harm to children and should be responded to by professionals following Trust Child Protection Guidance & the Safeguarding Children policy.

All health professionals must follow their Local Safeguarding Children Board (LSCBs) Child Protection Procedures

7.4 Adults with care and support needs

It is recognised that some victims of domestic abuse may face additional risk factors and that these should be taken into consideration when offering help and support. In England, 1.6% of older people (aged 66 years and over) reported experiencing abuse (psychological, physical, sexual and financial) in the past year from a family member, close friend or care worker (DH 2007).

Since 2014, a victim of domestic abuse with additional care and support needs can be referred to the local authority's adult safeguarding team in addition to any other care or support offered (The Care Act 2014). Care must be taken to get the victim's consent for the referral and the victim **must be unaccompanied by any family or friends** whilst consesnt is taken.

Patients lacking capacity can be referred to adult safeguarding as a best interest decision.

Forty per cent of the abuse was perpetrated by a partner and 43% by another family member. All health professionals must follow their Local Safeguarding Adult Protection Procedures & the HEFT Adult Safeguarding Policy

7.5 Links between domestic abuse and ill health

There are numerous short and long term physical and mental health consequences of domestic abuse for victims and children living within a household where domestic abuse takes place.

For women age 19-44, domestic abuse is the leading cause of morbidity – greater than cancer, war and motor vehicle accidents - and is the leading cause of injury and illness for girls and women aged 15-44. In the UK Domestic abuse claims the lives of two women per week.(DOH 2005)

Domestic abuse is a key public health issue and treating related physical injuries and addressing mental health need, costs the National Health Service in the region of £1.7 billion per annum (Walby, 2009).

Healthcare settings may be a survivor's first or only point of contact with professionals and abused women are more likely to be in touch with health services than any other agency (DOH, 2005). Eighty percent of women in a violent relationship seek help from health

services at least once (DOH, 2000) and women suffering from the effects of domestic abuse typically make 7-8 visits to health professionals, either on their own or on someone else's behalf, before disclosure of abuse (Harris, 2002).

In addition, between 4% and 19.5% of women attending healthcare settings in England and Wales may have experienced domestic violence in the past year. A high proportion of women attending accident and emergency, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence at some point (Alhabib et al. 2010; Feder et al. 2009). Between 30% to 60% of female psychiatric inpatients also report experiencing domestic violence in their lifetime (Howard et al. 2010).

7.6 Recognition of domestic abuse in adults

The following are potential indicators of domestic abuse which may trigger the need for selective enquiry. (There appears to be no difference between male and female victims and the signs and symptoms they present with):

- Frequent appointments for vague symptoms
- Frequent missed appointments
- Injuries inconsistent with explanation of cause
- Patient tries to hide injuries or minimise their extent
- Partner is aggressive or dominant, talks for the patient or refuses to leave the room when asked
- Partner always accompanies patient for no apparent reason
- Patient is submissive and/or reluctant to speak in front of partner; they appear frightened, overly anxious or depressed
- Multiple injuries at different stages of healing
- Injuries to the breast or abdomen
- Injuries to face, head or neck- common injuries include perforated eardrums, detached retinas
- Recurring sexually transmitted infections or urinary tract infections
- Hair loss- consistent with hair pulling
- Presentation with alcohol and/or substance abuse, depression, anxiety, self-harm, eating disorders or psychosomatic symptoms
- Obsessive compulsive disorder
- Suicide attempts
- History of repeat miscarriages, terminations, still births or pre-term labour
- Poor contraceptive use
- Poor or non-attendance at antenatal clinics
- Non-compliance with treatment
- Early self-discharge from hospital

7.7 Recognition of Domestic Abuse in Children

Whilst a child will respond differently to the abuse they have witnessed or experienced depending on their age, their personal resilience and support mechanisms, there is evidence that children suffer long term damage through living in a household where

domestic abuse is taking place even though they themselves may not be directly harmed. Their emotional, physical and psychological development may be impaired.
Impact on the child or young person's health can include:

- Physical injury e.g broken bones and bruises
- Death
- Neurological complications
- Premature birth, low birth weight and/or brain damage
- Failure to thrive or weight loss
- Stress related illness, asthma, bronchitis or skin conditions
- Speech and language delays
- Tiredness and sleep disturbance
- General poor health
- Enuresis or encopresis
- Substance and alcohol misuse
- Mental health issues such as depression and anxiety
- Eating disorders
- Damage following self-harm
- Teenage pregnancy
- Low self-esteem and self confidence
- Behavioural and emotional disturbance
- Introversion or withdrawal
- Thoughts of suicide or running away
- Post-traumatic stress disorder
- Anger, aggressive behaviour and delinquency
- Assumes a parental role
- Hyperactivity
- Sexual problems or sexual precocity
- Suicide attempts
- Difficulty in making and sustaining friendships
- Truancy and other difficulties at school

"Domestic violence perpetrated by a parent is a significant indicator of failed and dangerous parenting by that parent. It will also significantly impact on upon the parenting capacity of the victim who will usually be trying to parent and keep the children safe. An imperative of any intervention for children living with domestic abuse is to support the non-abusive parent"

From: West Midlands Domestic violence and Abuse Standards September 2015

8. National and Local Context

8.1 National context

An estimated 1.2 million females and 677,000 males aged 16 to 65 in England and Wales (8% and 4% respectively of the population as a whole) were victims of domestic violence in the year 2009/10. At least 29% of women and 16% of men in England and Wales (over 7.3 million adults) have experienced it (Home Office 2011). Domestic violence can be sexual, 'non-physical' – comprising emotional or financial threats, or physical (using 'minor' or 'severe' force). 'Honour' violence and forced marriage are examples of domestic violence that particularly affect black and minority ethnic groups in England (Home Office 2010a). These figures are likely to be an underestimate, as domestic violence is under-reported. 80% of psychological, physical and sexual abuses are perpetrated by men.

Since 1995, approximately half of all female murder victims aged 16 or over in England and Wales were killed by their partner or ex-partner. 12% of male murder victims have been killed by their partner or ex-partner since 1995.

8.2 The cost of domestic abuse:

Domestic abuse cost the UK an estimated £15.7bn in 2008 (Walby 2009). This included:

- just over £9.9bn in 'human and emotional' costs
- over £3.8bn for the criminal justice system, civil legal services, healthcare, social services, housing and refuges
- over £1.9bn for the economy (based on time off work for injuries)

8.3 Local context

Birmingham consistently has the highest number of reported domestic abuse incidents within West Midlands Police region.
15,495 domestic violence incidents reported to the police, of which 30% were repeat calls (West Midlands Police 2010)
3 Domestic related murders and 6 attempted murders (ibid)
1149 homeless applications due to domestic violence
(Birmingham City Council 2011)
1548 women and children sought emergency refuge accommodation
(Birmingham City Council 2011)

9. Training Requirements

Level 2 safeguarding children and adults is delivered at corporate induction to all clinical staff. The training includes information on domestic abuse, recognition, appropriate responses and referral processes.

Staff that requires level 3 safeguarding training are identified through HEFT training strategy and matrix. These staff can access multi-agency LSCB and LSAB training which includes domestic abuse training events.

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10. Monitoring and Compliance

The Lead Nurse for Safeguarding will monitor compliance of this policy. This will include monitoring the number of Domestic Abuse cases involving a child and the number involving an adult, and their outcome which will be reported to the Executive Chief Nurse and Trust Care Quality Group.

See Appendix 1

11. References and Associated Documentation

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West Midlands Domestic Violence and Abuse Standards (West Midlands Preventing Violence against Vulnerable People Board September 2015)

Appendix 1 Monitoring and Compliance

Requirement to be monitored	Process for monitoring	Responsible group /individual	Frequency of monitoring	Responsible group/ individual for review of results	Responsible committee/ group for development of action plan where required
Adults with care and support needs; victims of domestic abuse should only be referred to safeguarding if they meet this criteria.	Domestic abuse database	Lead Nurse for Safeguarding Adults and Domestic Abuse	Annually	Domestic Abuse steering group Safeguarding Adults steering group	Domestic Abuse steering group
Supporting victims without care and support needs by referring to appropriate services	Domestic abuse database	Lead Nurse for Safeguarding Adults and Domestic Abuse	Annually	Domestic Abuse steering group Safeguarding Adults steering group	Domestic Abuse steering group

Appendix 2 Domestic Abuse Support Services

Name	Area of expertise	Contact
Action on Elder Abuse	Information and support for **older people** experiencing abuse or people who have witnessed abuse	www.elderabuse.org.uk
Akina Mama wa Africa	Advice, information and counseling for **African Women** on domestic violence, Aids, HIV and mental health	www.akinamama.org
Bharosa	Domestic abuse service for **ethnic minority women** (particularly those from a South Asian background) living in **Birmingham.**	bharosa@birmingham.gov.uk
Birmingham and Solihull Women's Aid	Supports **women and children** affected by domestic violence, rape and sexual assault.	http://bswaid.org/
Birmingham LGBT	Delivers independent domestic violence advocacy and support for **LGBT** people in Birmingham	http://blgbt.org/domestic-violence/
ManKind	A national charity that provides help and support for **male victims** of domestic abuse and domestic violence.	www.mankind.org.uk
Mencap	Help and support for people with **learning disabilities.**	https://www.mencap.org.uk/
Refuge	For **women and children** through a range of services including; refuges, independent advocacy, community outreach and culturally specific services.	www.refuge.org.uk
Respect	Offers help and advice to **people who are abusive** to their partners and want to stop.	www.respect.uk.net
Rise	Supporting any **lesbian, gay, bisexual, trans, queer or intersex person** experiencing domestic violence and abuse.	http://www.riseuk.org.uk/?PageID=106#.VdWh1vn49dg
Roshni Birmingham	Support for **Asian women and children** who have suffered from domestic violence and forced marriages.	http://roshnibirmingham.org.uk/
Saheli Asian Women's project	Providing safe and culturally familiar space for **Asian women.**	http://saheli.org.uk/
Shelter	Practical and emotional support for **homeless families, single parents** and **pregnant women**. Support for victims of domestic violence.	http://england.shelter.org.uk/
Tamworth Pathways Project	Supports **adults, young people and children,** who are experiencing or affected by domestic abuse.	www.pathway-project.co.uk

Appendix 3 Basic Safety Plan

Basic Safety Plan

Patients: Who have experienced Domestic Abuse

IMPORTANT NUMBERS

- Police …… ☎ 999 in an emergency
- 24 hour Domestic Abuse helpline: ☎ 0808 2000 247
- Birmingham & Solihull Women's Aid helpline: ☎ 0808 800 0028 (9.30am – 5pm)
- Emergency Refuge in Birmingham 24hrs: ☎ 0800 111 4223
- Safe Person ……..…..
- Housing…….....
- Children's school…….....……..

DURING A CRISIS

- PHONE THE POLICE – 999
- Phone 'safe' person from mobile - when you want the police to be called say agreed code word
- Move to a room with an exit.
- Move towards the front door rather than back so you can run for help
- Avoid rooms that are potentially dangerous (e.g. the kitchen where there are knives)
- Carry charged mobile phone with you at all times
- Alert older children to potential attack with 'code word' which is their prompt to run to safety and phone police.

BEFORE A CRISIS

- Identify 'safe' person you will phone during a crisis
- Agree on 'code word' as sign to phone police
- Keep mobile phone fully charged and 'topped up' at all times
- Identify where you will make an emergency call if mobile snatched?
- Identify and practice escape routes from your home
- Keep car filled up with petrol
- Keep spare car and home keys by escape route/ spare keys by escape route
- **Organise an escape bag.** Include; Passport, Birth certificate, Benefits book, Driving license, NI number. **Also pack**; Change of clothes, medication, snacks, spare money, and list of important numbers. Include items you know you can't live without; Children's favourite toy, photos, keepsakes.
- Keep escape bag by escape route or with safe person
- Rehearse escape route with children and teach them how to phone police Tell children where to run to for safety during an attack.
- Identify where and when you are most vulnerable to an attack and take action to increase your safety

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The following forms are for use by maternity and paediatric services only

Appendix 4 Domestic Violence Risk Identification Matrix (DVRIM)

DVRIM: Level of risk Moderate Scale 1. CAF: Level 2 Threshold of need child with additional needs.

Child/ren & families with additional needs. CAF completed- Single Practitioner targeted support – Child/ren under 7yrs/ or with special needs increases risks. The younger the child/ren the higher the risk to their safety. Consider protective factors.

Evidence of Domestic Violence	Y	S
1 - 3 minor incidents of physical violence which were short in duration.	✔	
Victim did not seek medical treatment.		
Intense verbal abuse.		

Risk factors/ Potential vulnerabilities	Y	S
Child/ren were not drawn into incidents.		
Control by abuser is not intense.		

Protective factors	Y	S
Child/mother relationship is nurturing, protective and stable.		
Significant other in child's life - positive and nurturing relationship.		
Presence of child/ren was a restraint for the abuser.		
Abuser accepts responsibility for abuse and violence.		
Abuser indicates genuine remorse and is willing to seek support for abusive behaviour.		
Victim has positive support from family/ friends & community.		
Victim appears emotionally strong (not worn-down by the abuse).		
Victim sought appropriate support and/or is willing to accept help from other agencies.		

BME (Black, Minority, Ethnic) Issues: Across all scales

Ask yourself the following questions:
If this parent...
1 Cannot speak, read or write English
2 Fears that the 'State' is authoritarian
3 Lacks strong social networks
4 Lives in temporary housing
5 Is living below the poverty line
6 Has a child who is of a different appearance and culture to them
7 Is living in a close-knit community in London
8 Has a perspective on parenting practices underpinned by culture or faith which are not in line with UK law & cultural norms
9 Recognises his/her faith or community leader as all powerful
10 Puts a very high value on preserving family honour
and, if this young person...
11 Is compromised in relation to his/her community
12 Has strong allegiance to a group or gang

If you need further information, please refer to the BME checklist, downloadable from the LSCB website.

Believe in children
Barnardo's
www.barnardos.org.uk

DVRIM: Level of risk Moderate to Serious Scale 2. CAF: Level 2 Threshold of need child with additional needs.

Child/ren & families with additional needs. CAF completed –Lead professional-integrated support Child/ren under 7yrs/or with special needs - at higher risk of emotional/ physical harm – limited self-protection strategies -can raise threshold to Scale 3. Consider protective factors.

Evidence of Domestic Violence	Y	S
History of minor/moderate incidents of physical violence- short duration.		
Victim received minor injuries - medical attention not sought.		
Evidence of intimidation/bullying behaviour - pushing/ finger poking/ shoving/to victim but not towards child/ren - Destruction of property.		✔
Intense verbal abuse-consistent use of derogatory language.		
Risk of isolation - Abuser attempts to control victims' activities, movements & contact with others.		

Risk factors/Potential vulnerabilities	Y	S
Child/ren were present in the home during an incident but did not directly witness.		
Potential likelihood of emotional abuse of children.		
BME (Black, Minority, Ethnic) Issues: See Blue Box.		
Disability issues within family - positive support networks.		
Mental health issues - not prolonged or serious. Abuser or victim seeking appropriate help.		
Age of abuser and/or Victim - both have supportive resources and are not isolated.		

Protective factors	Y	S
Child/mother relationship is nurturing, protective & stable.		
In spite of abuse, victim was not prevented from seeing to the needs of her child/ren.		
Significant other in child's life - positive and nurturing relationship.		
Older child/ren use coping/ protective strategies.		
Victim attempted to use protective strategies with older child/ren.		
Victim is prepared to take advice on safety issues.		
Victim has insight into the risks to her child/ren posed by the abuse.		
Victim has positive support from family/friends and community.		
Abuser willing to engage in services to address his abusive behaviour.		

Barnardo's Domestic Violence Risk Identification Matrix

Assessing the risks to children from male to female domestic violence.

DVRIM: Level of risk Serious Scale 3. CAF: Level 3 Threshold of need child with complex needs.

Child/ren in Need - Children's Services may consider Section 17 but Safeguarding intervention may be necessary if threshold of significant harm is reached. Professional case planning Child/ren aged under 7yrs/ or child/ren with special needs can raise threshold to scale 4

Evidence of Domestic Violence	Y	S
Incident(s) of serious and/or persistent physical violence in family. Increasing in severity/frequency and/or duration - History of previous assaults.		
Victim and/or children indicate that they are frightened of abuser - put in fear by looks, actions, gestures and destruction of property (emotional & psychological abuse). Recent separation - repeated separation/reconciliation/ongoing couple conflict.		
Stalking/harassment of mother/children - Increased risk of isolation.		
Abuse through the use of texting/social networking sites.		
Abuser breaching bail conditions/civil protective orders / non-contact orders.		
Victim required medical treatment but not sought/or explanation for injuries implausible.		
Recurring or frequent requests for police intervention.		
Incident(s) of violence occur in presence of child/ren - consider duration of exposure.		
Threats of harm to mother/and or children.		
Excessive jealousy/possessiveness of abuser - domineering in relationship.	✔	
Financial control maintained by abuser.		
Abuser has history of domestic violence in previous relationships.		

Risk factors/Potential vulnerabilities	Y	S
Mental health issues - abuser and/or victim-raises concern.		
Substance abuse by abuser and/or victim-raises concern.		
Abuser's and/or victim's infidelity is a source of conflict/anger		
Strong likelihood of emotional abuse of child/ren - may display behavioural problems.		
Child/ren unable to activate safety strategies due to fear or intense control by abuser.		
Lack of safe significant other as a positive support to child.		
Child contact issues - domestic abuse occurring at contact.		
Older children /Adolescent - increased risk of intervening in abuse and emerging concerns re self harm.		
Abuser suspected of using physical abuse towards child/ren.		
Abuser shows lack of insight/empathy into how his behaviour effects children/victim.		
Abuser's minimisation of abuse-lack of remorse/guilt.		
Abuser is Boyfriend/Father figure. Family unit has step-siblings.		
Abuser's abuse of pets/animals/used to intimidate.		
Emerging concerns about emotional stability of abuser's relationship with child/ren/ limited parenting capacity & lack of protective abilities.		
Emerging concerns about emotional stability of child/mother relationship (parenting capacity and protective concerns).		
Emerging concerns of neglect of child/ren's emotional and physical needs-missed health appointments/poor living conditions.		
Abuser's use of avoidance/resistance to engage in services increases risk level to children.		
Victim fears statutory services - avoidance & resistance to engage increases risk to children.		
Family/Relatives/neighbours reports concerns re victim/children.		
Victim has experienced domestic violence in previous relationships.		
BME (Black, Minority, Ethnic) Issues: See Blue Box.		
Adult learning difficulties-abuser and/or victim-raises concern.		
Disability issues within family - isolation.		
Age disparities of Abuser/Victim - under 25 with limited support with personal vulnerabilities.		
History of childhood abuse/disruptive childhood experiences - abuser and/or victim.		
Collusion issues present in extended families/friends - not supportive for victim/children.		
Recent life crises/stress factors - i.e unemployment, financial problems, illness, death.		

Protective factors	Y	S
Older child/ren use protective strategies.		
Victim will seek positive support from significant other.		
Victim - attempts to use protective strategies but abuser's violence & control is intense.		
Victim will engage with supportive services and seek safety advice - be alert to control interfering with her level of commitment to engage.		
Limited protective factors are present - serious level of violence and psychological abuse of victim, emotional abuse of child/ren and Domestic Violence risk factors predict recidivism.		
Use of kinship placements as a protective factor - be alert to domestic violence having occurred or occurring in extended families.		

DVRIM: Level of risk Severe Scale 4. CAF: Level 4 Threshold of need child with acute needs - at risk of being a 'looked after' child.

Child in need of Protection – Children's Services consider if Section 47 enquiry and core assessment intervention are required. Child/ren may be at risk of being 'looked after'.

Evidence of Domestic Violence	Y	S
Repeated serious and/or severe physical violence - life threatening violence. Attention to the **frequency, duration** and **severity** of violent behaviour children exposed to.		
Use/assault with weapons.		
Abuser's violation of protective and/or child contact orders.		
Criminal history of abuser, gangland connections, generalised aggression, history of anti-social behaviour, aggression towards previous partners/family members, military service/ training.		
Intense stalking/harassment behaviour of abuser - Increased risk of isolation.		
Recurring or frequent requests for police intervention.		
Victim requires treatment for injuries sustained - Medical attention required but not sought or injuries explanation is implausible.		
Threats to kill or seriously injure victim and/or children.		
Victim is very frightened of abuser - believes intent of threats - Retaliatory violence a concern. Victim is intensively controlled/may present as submissive - worn down by abuse.		
Victim is pregnant/victim is abused in post natal period/recently separated with new baby raises risk level.		
Confirmed emotional/psychological/abuse of mother.		
Sexual assault/suspected sexual abuse of victim.		
Incidences of violence witnessed & occurred in presence of children - distressed/aftermath of incident. Child/ren have directly intervened in incidences.		
Child/ren summon help/discloses-immediate heightened risk to this child of being 'punished' / adverse reaction from abuser and /or mother-assess adult's reaction to child's disclosure. Child/ren may disclose another form of abuse to draw attention to the situation.		
Child/ren have been physically assaulted/abused.		
Confirmed emotional abuse of child/ren.		
Suspected/confirmed sexual abuse of child/ren.		
Abuser is a perpetrator of child abuse but may not have been prosecuted. Known to MAPPA.		
Victim has been identified by DASH-MARAC process as high risk.		

Risk factors/Potential vulnerabilities	Y	S
Mental health issues - abuser and/or victim - raises significant concern.		
Substance abuse by abuser and/or victim - raises significant concern.		
Abuser's and/or victim's infidelity is a source of conflict/anger -Victim's infidelity gives rise to risk of severe reactive violent response from abusive partner-extreme jealousy/ possessiveness.		
Concerns of neglect of child/ren's emotional and physical needs/poor living conditions.		
Substantial risk of repeated serious domestic violence.		
Threats or attempts to abduct children.		
Children exhibit sexualised behaviour and/or sexually harmful behaviour.		
Adolescent - increased risk of intervening in abuse and self harm-emerging concerns re mental health issues.		
Child/ren in family has previous care history.		
Physical abuse of child/ren by abuser and/or victim.		
Victim uses physical abuse on children as an alternative to harsher physical abuse by abuser.		
Recent suicidal or homicidal ideation/intent by abuser.		
Victim suicidal/attempted suicide/self harming - especially BME victims.		
Victim minimising risks to children/remains in abusive relationship, protection orders not sought, or activated.		
Victim/child has poor general health.		
Abuser shows lack of empathy/insight into how his abusive behaviour is affecting child/ victim.		
Abuser's minimisation of abuse-lack of remorse/guilt.		
BME (Black, Minority, Ethnic) Issues: See Blue Box		
Age disparities - Abuser and/or victim under 25 with limited support with personal vulnerabilities.		
Collusion issues present in extended families/friends - not supportive for victim and children.		
History of childhood abuse/disruptive childhood experiences abuser and/or victim.		
Abuser uses threatening aggressive behaviour towards professionals.		
Agencies unable to work constructively with family 'Assessment Paralysis'.		
Abuser/victim use of avoidance/resistance to engage - misuse of complaints procedures.		

Protective factors: See Scale 3.	Y	S

MARAC Referral

Appendix 5 MARAC Referral

Disclosure of domestic abuse

Assess victim's situation using the DVRIM
Carry out immediate safety measures for victim, perpetrator and children

Victim is assessed as low risk

- Give information about support services such as Women's Aid, Barnado's etc.
- Support victim to keep themself safe
- Document your concerns in a place that the perpetrator will not be able to access them

Victim is assessed as high risk

- The police will carry out target hardening[1] and child protection agencies will keep the children safe
- Refer to IDVA[2] service
- Complete MARAC referral form
- Inform colleagues that referral has been

- MARAC co-ordinator receives referral and sends an agenda for the cases to be considered
- Research the cases, liaising with other colleagues as necessary to gain more information
- IDVA will gather further background information from the victim and other agencies not represented at the MARAC
- Each agency's MARAC representative presents information on their services and referrals
- Identify risks to the victim, children, perpetrator, and staff
- Each agency's MARAC representative contributes to any other case under discussion that they have had involvement in
- IDVA presents information on behalf of the victim including key risks and fears identified by the victim

- Each agency develops SMART objectives for keeping the victim safe
- Identify areas for partnership / MDT working
- IDVA confirms satisfaction that the actions will keep the victim as safe as possible

- IDVA informs victim of the safety plan where safe to do so and liaises with other services to co-ordinate the plan
- Inform colleagues of actions, complete actions within agreed time and inform MARAC co-ordinator when action are complete

KEEP IDVA INFORMED ALL RELEVANT INFORMATION

[1]The process by which police officers make a target more resistant to attack or make it harder to remove or damage for example, upgrading locks on windows or doors.

[2]Independent Domestic Violence Advisor / Advocate. Their role is to address the safety of victims at high risk of harm to secure their safety and the safety of their children.

Appendix 6 DASH Risk Identifcation Checklist

The DASH Risk Checklist can be found here

Appendix 7 MARAC referral

MARAC Referral

Referring agency			
Contact name(s)			
Telephone / Email			
Date			
Victim name		**Victim DOB**	
Address			
Telephone number		**Is this number safe to call?**	
Please insert any relevant contact information, eg times to call			
Diversity data (if known)	B&ME Disabled LGBT Gender		
Perpetrator(s) name		**Perpetrator(s) DOB**	
Perpetrator(s) address		**Relationship to victim**	

Children (please add extra rows if necessary)	**DOB**	**Relationship to victim**	**Relationship to perpetrator**	**Address**	**School** (If known)

ummary of events /reason for referral to marac	
Expectations from MARAC	
Case History	

CURRENT INFORMATION

Previous history victim	

Children	
Dash questions	
Previous history perpetrator	
Current status of perpetrator including bail conditions/restraining orders etc	

Serial perpetrator yes/no	
PPU updates/contact information	

ACTIONS

Actions completed prior to MARAC	