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CONTENTS

1. SUMMARY

The health service is in a unique position to help people who experience domestic abuse and to facilitate individuals to get the support they need.

This guidance aims to:

- Develop a multidisciplinary approach in which professionals work in partnership with the person in order to empower them to find their own solutions in seeking support, information, advocacy, advice, refuge or protection for themselves and any dependants they may have.
- Enable professionals to respond swiftly and consistently to domestic abuse.
- Assist professionals to identify and support individuals who may be experiencing domestic abuse.

In the majority of cases, particularly where there are child protection concerns, victim/survivor is female and the perpetrator is male. However, domestic abuse can also be perpetrated by women against men; and within same sex relationships; to or by a child/young person or to a vulnerable adult by their carer.

This guidance should therefore be applied to all situations of domestic abuse. The Lancashire and Cumbria domestic abuse services and Multi Agency Risk Assessment Conference (MARAC) Appendix 1 and 2 processes will support all victims of domestic abuse irrespective of age, gender or sexuality. It should be read in conjunction with both Cumbria and Lancashire LSCB and LSAB Multi Agency Policies and Procedure.

- Lancashire Local Safeguarding Children Board (LSCB)[1]
  http://panlancashirescb.proceduresonline.com/chapters/p_domestic_violence_abuse.html

- Cumbria Local Safeguarding Children Board (LSCB)[2]
  http://www.cumbrialscb.com/professionals/domesticabuse/default.asp

- Pan-Lancashire and Cumbria Local Safeguarding Adult Board (LSAB)[3]
  http://www.lancashiresafeguarding.org.uk/media/48734/Domestic-Abuse-Guidance.pdf

UHMBT note that local Safeguarding Children's Boards have been replaced with new partnership working relationships from September 2019 however for this policy, the hyperlinks remain accessible.

1.1 Definition

Domestic abuse is defined by the Home Office (updated 2013) 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:

- ***Psychological*** *- Intimidation, threats to harm, threats to kidnap children, blackmail, destruction of pets, property, mind games and stalking*

- ***Physical*** *- Inflicting or attempting to injure, grabbing, pinching, biting, kicking, stabbing, weapons, withholding medications, food, funds*
- *Sexual - Marital rape, acquaintance rape, forced sex after physical beating, fondling, forced prostitution*
- ***Financial*** *- Maintaining control of earned income, withholding money and running up debt in the victim's name*
- ***Emotional*** *- Undermining or attempting to undermine the victims' sense of worth, constant criticism, name calling, insults, put downs, silent treatment, repeatedly making and breaking promises, harming or making threats to harm pets*
- ***Controlling behaviour*** *- 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 their victim.*
  In the Serious Crime Act 2015[4] a new offence was created of controlling or coercive behaviour in intimate or familial relationships.
  https://www.gov.uk/government/collections/serious-crime-bill
- ***Stalking and Harassment*** *(Home Office 2012) Behaviour which is happening more frequently or escalating in terms of the level of violence used - this might include indirect threats; and the occurrence of destruction or vandalism of property belonging to either the victim or someone else. Frequent unwanted contact, for example, attending at the home or the workplace of the victim, telephone calls, text messages, emails or use of other mechanisms such as the internet and social networking sites; driving past the victim's home or work; following or watching the victim; sending letters or unwanted 'gifts' or items to the victim; threats of physical harm to the victim (including sexual violence and threats to kill); physical and/or sexual assault of the victim and even murder.*

This definition includes acts perpetrated by extended family members as well as intimate partners.

This includes, 'honour' based violence which can include abduction and homicide, female genital mutilation (FGM) and forced marriage, and is clear victims are not confirmed to one gender or ethnic group.

Lancashire and Cumbria procedures for Forced Marriage can be found on the Local Safeguarding Children Board websites accessed via the safeguarding intranet page http://UHMBT/cs/safeguarding/Pages/default.aspx

In 2013 the Government widened the definition to include young people under 18 years and worded this to reflect coercive control.

Domestic violence/abuse is prevalent within every community, regardless of age, race, and sexuality, social or economic status. Research indicates that the majority of those most frequently and severely impacted are female. This procedure is non-gender specific but highlights the need of services to address needs of specific groups e.g. maternity or women's health services, initiatives to support male survivors, lesbian, gay, bisexual, transgender (LGBT) services or victims of hate crimes including so called 'honour,' based violence or, 'forced marriage'.

According to The Crime Survey for England and Wales ending March 2019 an estimated 5.7% of adults aged 16 - 74 years (2.4 million) experienced domestic abuse in the last year. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2019

The main characteristic of domestic abuse is that the behaviour is intentional and is calculated to exercise power and control within a relationship.

Alongside the physical injuries inflicted in a violent incident, on-going abuse will have a negative impact on health and is frequently a primary cause of mental health issues and chronic health problems for those affected. Individuals experiencing domestic abuse present frequently to health services and this provides an ideal opportunity to identify and support individuals experiencing domestic abuse.

A woman and her unborn child are at increased risk during pregnancy. Domestic abuse is more likely to begin or escalate during pregnancy or the postnatal period; and existing abuse may get worse during pregnancy or after birth. Domestic abuse during pregnancy puts the mother and baby at risk, including risk of miscarriage, infection, premature birth and injury or death to the baby. It is a significant reason for admission during pregnancy and cause of maternal and perinatal mortality.

- More than 30% of cases of domestic violence start during pregnancy.
- Over a third of domestic abuse starts or gets worse when a woman is pregnant.
- 15% of women report violence during pregnancy.
- More than 14% of maternal deaths occur in women who have told their health professional they are in an abusive relationship.
- 40% - 60% of women experiencing domestic violence are abused whilst pregnant.
- 1in 4 Women experience domestic abuse over their lifetimes.
- On average, a woman is assaulted 35 times before her first call to police (Office for National Statistics 2018 and NSPCC website).

1.2 Victim/Survivor

It is important to recognise that the term “victim / survivor’ can be perceived as negative and every effort should be made to ensure that people are being addressed in a way that they are comfortable.

1.3 Children are also at Risk

- In over 50% of known domestic abuse cases, children were also directly abused.
- In 90% of domestic abuse incidents, children were in the same or next room
- Over three quarters of children ordered by the courts to have contact with a violent parent were abused further as a result of contact being set up.
- 1:5 children have been exposed to domestic abuse.
- Department of education figures from 2018 show that domestic abuse was a factor in ¼ million of child protection assessments across England.
- Nearly three quarters of children on Child Protection Plans live in households where domestic violence occurs.
- Under the Adoption and Children Act 2002[5] living with or witnessing domestic violence is identified as a source of significant harm for children in such cases. It is most effective to provide support and protection to the abused individual so that they are able to protect

the children. NSPCC website

1.4 Forced Marriage and Young People

Forced Marriage is a marriage conducted without the full consent of both parties and where duress is a factor. The Governments Forced Marriage Unit[6] produce guidelines and these are available at https://www.gov.uk/forced-marriage It may be possible to recognise some of the warning signs that a young person may be at risk of forced marriage.

Many women may assume that the health professional cannot help them, for this reason it is unlikely that a woman will present to a health professional as a victim of forced marriage. If a health professional is aware of forced marriage and the ways in which women can be helped they are in an ideal position to provided early and effective intervention.

During **routine enquiry about domestic abuse** it may be useful to incorporate forced marriage into the routine questions for young people from black and ethnic minority communities; here the questions may focus on the family relationship.

- How is your relationship?
- Are you happy about the baby?
- Is your partner happy?
- Does your partner or family let you do what you want, when you want?
- Have you ever been afraid of your partner's or family member's behaviour? Are they verbally abusive?
- Do you feel unsafe at home?
- How are things at home - do you get on with your parents / in-laws?'

Where a health professional does elicit information that suggests a woman is facing a forced marriage refer to: https://www.gov.uk/guidance/forced-marriage

In cases where there are concerns that a young person under 18 years may be at risk of forced marriage, a referral must be made to the Children's Social Care, in line with local procedures. Do not inform the family of your intention to refer to social care.

1.5 Female Genital Mutilation (FGM)

FGM is collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. FGM is a form of child abuse.

FGM has been a criminal offence in the UK since 1985. In 2003 the Female Genital Mutilation Act[7] made it an offence for UK nationals or permanent UK residents to carry out FGM abroad or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where it is legal.

Further information about the Act can be found in Home Office circular 10/2004[8] which is available on:
https://webarchive.nationalarchives.gov.uk/20130309162644/http://www.homeoffice.gov.uk/about-us/corporate-publications-strategy/home-office-circulars/circulars-2004/010-2004/

All suspected cases of FGM must be discussed with the Safeguarding team.

Female Genital Mutilation - Information Sharing (FGM-IS)
The Female Genital Mutilation - Information Sharing (FGM-IS) is a national IT system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation (FGM).

The FGM-IS is part of the NHS Spine and healthcare professionals can view, add and remove the FGM indicator. It is accessed via the Summary Care Record Application (SCRa). Access is controlled via NHS smartcards and the appropriate permissions, so only authorised healthcare professionals can access the FGM information.

The FGM-IS contains an indicator that the girl has a family history of FGM and the date that the FGM indicator was added to the system. As this is a national system it allows authorised healthcare professionals to view information about girls with a family history of FGM, regardless of location.

This allows for relevant and timely information sharing and provides an opportunity to provide the appropriate support to the girl and her family.

The safeguarding team will be responsible for adding and/or removing FGM indicators but all necessary healthcare staff within UHMBT will be able to view FGM-IS.

1.6 'Honour' Based Violence (HBV)
'Honour' based violence is a form of domestic abuse which is perpetrated in the name of so called 'honour'. The honour code which it refers to is set at the discretion of male and / or female relatives who do not abide by the 'rules' are then punished for bringing shame on the family. Infringements may include a woman having a boyfriend; rejecting a forced marriage; pregnancy outside of marriage; interfaith relationships; seeking divorce, inappropriate dress or make-up and even kissing in a public place.

HBV can exist in any culture or community where males are in position to establish and enforce women's conduct, examples include: Turkish; Kurdish; Afghani; South Asian; African; Middle Eastern; South and Eastern European; Gypsy and the travelling community (this is not an exhaustive list).

Males can also be victims, sometimes as a consequence of a relationship which is deemed to be inappropriate, if they are gay, have a disability or if they have assisted a victim. Support is available through the ManKind Initiative. https://www.mankind.org.uk/

1.7 Domestic Violence Disclosure Scheme (DVDS) (also known as 'Clare's Law')[9]
Domestic Violence Disclosure Scheme (DVDS) (also known as 'Clare's Law') commenced in England and Wales on 8th March 2014, guidance was produced in December 2016.

The DVDS gives members of the public a formal mechanism to make enquires about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner. This scheme adds a further dimension to the information sharing about children where there are concerns that domestic violence and abuse is impacting on the care and welfare of the children in the family.

Members of the public can make an application for a disclosure, known as the 'right to ask'.

Anybody can make an enquiry, but information will only be given to someone at risk or a person in a position to safeguard the victim. The scheme is for anyone in an intimate relationship regardless of gender. Partner agencies can also request disclosure is made of an offender's past history where it is believed someone is at risk of harm.
This is application is described as 'right to know'.

If a potentially violent individual is identified as having convictions for violent offences, or information is held about their behaviour which reasonably leads the police and other agencies to believe they pose a risk of harm to their partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

It is important to be aware that DVDS disclosures can be really distressing for the individual, can escalate their risk (as they know something the perp doesn't know they know) and should ideally (if it is a HCP making the 3rd party request) be accompanied by robust counselling and safety planning if disclosure is made.

2. PURPOSE

This procedure stipulates the mandatory arrangements for UHMBT staff in the identification of and response to potential or actual domestic abuse.

To safeguard children, young people and adults effectively the principles outlined in this procedure should be followed:

- The safety of victim and children is the primary concern in any intervention.
- Health professionals should empower victims to make their own decision and not make a decision on their behalf.
- Health professionals should not extend their roles to include in-depth support where other agencies might have more experience.
- Information sharing is beneficial if carried out appropriately and safely.
- Appropriate levels of confidentiality should be respected
- Staff should not put themselves or their colleagues at risk in a potentially violent situation.
- Contrary to belief, deciding to leave an abusive partner doesn't mean a victim is safe. It is at this point that the victim is most at risk of serious injury or being murdered.
- Staff should never advise a victim to leave, but should encourage liaison with specialist DVA services to enable robust safety planning to commence.
- When a person is identified as high risk of domestic abuse a referral to Multi-Agency Risk Assessment Conferencing process (MARAC) should be made.

Cumbria MARAC operating procedure

Pan Lancashire MARAC Operating Protocol

- To demonstrate that UHMBT NHS Trust is a learning organisation ensuring that lessons learnt from Domestic Homicide Reviews and Improving Child Protection and Safeguarding Practice (formally known as serious case reviews).

3. SCOPE

- All those who come into contact with children, young people and their families in their everyday work, have a duty to ask about and respond to domestic abuse and to consider this in the wider sphere of safeguarding.
- All staff should also be familiar with the trust policies and procedures for safeguarding children, young people and adults at risk.
- All staff should be familiar with the Lancashire and Cumbria Multi Agency Risk Assessment Conference (MARAC) processes; which includes guidance on the use of the Risk Indicator Checklist (RIC), this is a risk assessment tool specifically designed to identify and refer high risk domestic abuse victims and its use should be promoted within UHMBTHT. (See Appendices for relevant risk assessment toolkits).
- All health professionals working directly with children, young people and adults should ensure that safeguarding and promoting their welfare forms an integral part of all stages of care.
- All staff should be alert to the potential indicators of abuse and neglect in children, young people and adults, know how to act on their concerns and fulfill their responsibilities.
- All managers and supervisors at UHMBT should have an awareness and understanding of the principles within this policy when supporting their staff and this policy will apply to staff at UHMBT where appropriate.

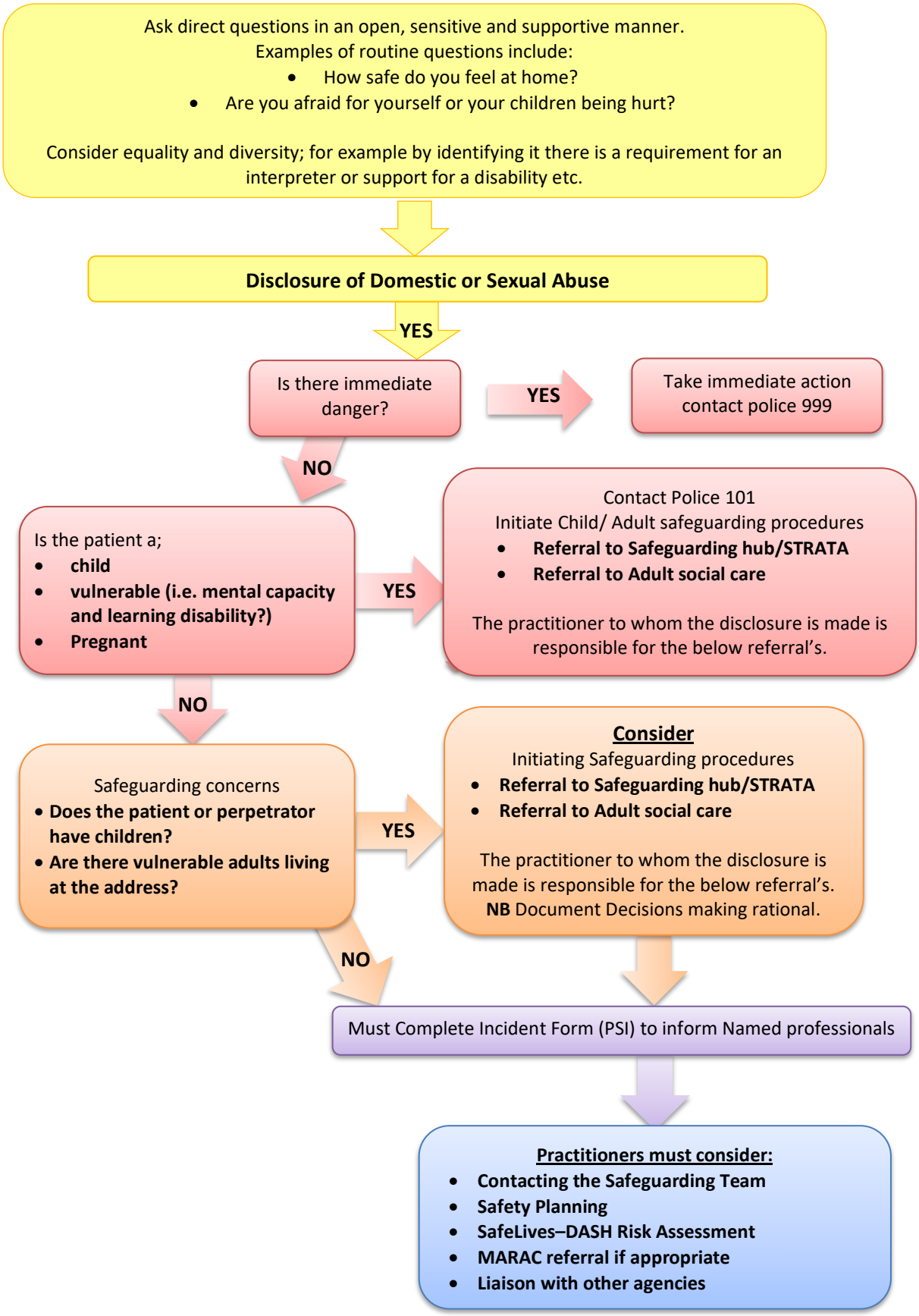
4. PROCEDURE

4.1 Role of the Health Professional

- Health Professionals are often a first point of contact for victims, and they deal with the after effects of domestic abuse on an everyday basis.
- Victims at risk might not come into contact with any other professionals who can offer a lifeline.
- Victims' health records can play an important part in bringing perpetrators to justice.
- Victims say they want us to take the initiative.
- Health Professionals are required to follow this Domestic abuse guidance in conjunction with the relevant UHMBT Adult and Child "Who to tell guidance"

Additional Sources of information for practitioners:
DoH (2017) Responding to domestic abuse: A resource for health professional.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf
SafeLives – Ending domestic abuse (2016) A Cry for health: Why we must invest in domestic abuse services in hospitals.
http://www.safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf
Children – UHMBT Who to Tell guidance
Adult – UHMBT Who to tell guidance:
http://UHMBT/cs/safeguarding/Process%20and%20Flowcharts/Who%20Do%20I%20Tell%20-%20Safeguarding%20Adults.pdf

Domestic Abuse referral Process



4.2 Record Keeping

Health records play an important role in responding to domestic violence. Records may form part of the future protection plan of an abused individual. Health professionals have a duty of care to record domestic abuse and permission need not be sought to document abuse in professional records.

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 or deportation cases.
- Housing provision.
- Civil procedures in family courts to assess the risks associated with granting an abusive parent contact with children.

Always keep detailed, accurate, contemporaneous and clear records of what you have discussed, even if your suspicions have not led to a disclosure; it might be of use in the future. If documenting a disclosure, use the victims' own words to describe what happened rather than your own, supported by your assessment on the impact of the abuse.

Notes on domestic violence/ abuse should, where possible, include:

- Demographic details of all involved both adults and children.
- Ethnicity.
- Response to routine or selective enquiry.
- Relationship to perpetrator, name of perpetrator.
- Whether the woman is pregnant.
- Presence of children in the household.
- Nature of abuse (emotional, psychological etc.) and injuries.
- Document any injuries observed, using trust approved body maps which currently can be found in Appendix 1 of UHMBT Safeguarding Adults Policy.
- Description of all kinds of abuse experiences and reference to specific incidents.
- Is this the first incident? If not, how long has it been going on and how often?
- Presence of enhanced risk factors e.g. disabilities, drug and alcohol misuse, mental health issue, homelessness etc.
- Consider using available domestic abuse risk assessment tools, for example the Safer Lives risk indicator checklist. **Risk Indicator Checklist**
- Documentation of information provided to victim on advice and support.
- Referrals made to other services, for example Adult Social Care, Children's Social Care, MARAC.

4.3 Enquiring about Domestic Abuse

Never ask about domestic violence when anyone else is present - including partners, children or any other family members. The only exception to this is when you need to use a professional interpreter (see Section 6 for policy CORP/GUID/001 Accessing Telephone and Face-to-Face Interpretation Services) or if the potential victim is deemed not to have capacity. If an interpreter is needed, never use a family member or friend. Disclosure may be

more likely when a telephone interpreting service is used, as the victim does not need to give details.

Victims should be listened to with respect and dignity and without judgment.

NICE (2014)[10] recommend that trained staff 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.

4.3.1 Selective Enquiry

Where a health professional is working with a victim and sees something that indicates the victim might be experiencing domestic abuse, or when the professional receives information from another source that domestic abuse is occurring, including the provision of information on domestic abuse; selective enquiry should be undertaken.

4.4 Possible Signs of Domestic Abuse

- Frequent appointments for vague symptoms.
- Frequent missed appointments.
- Partner is always in attendance.
- Victim is submissive or reluctant/afraid to speak in front of partner.
- Partner is aggressive or dominant, talks for the victim or refuses to leave the room.
- Victim appears frightened, overly anxious or depressed.
- Early, self-discharge from hospital.
- Non-compliance with treatment.
- Injuries inconsistent with explanation of cause.
- Victim tries to hide injuries or minimise their extent.
- Multiple injuries at different stages of healing.
- Injuries to breast or abdomen.
- Suicide attempts.
- Recurring sexually transmitted infections or urinary tract infections.
- History of repeated miscarriages, terminations, stillbirths or premature labour.
- Repeat presentation with depression, anxiety, self-harm or alcohol or drug misuse.

None of these signs automatically indicate domestic abuse, but they should raise suspicion and prompt you to make every attempt to see the patient alone and in private to ask if they are a victim of abuse.

When undertaking selective enquiry it is important that you:

- Avoid interruptions - the victim must feel it is important to you too.
- Be patient - this may be the first time the victim has spoken to anybody about their experiences. They may be scared of repercussions and may feel embarrassed or ashamed.
- Be supportive - this may seem obvious but the victim may feel that you are making judgements about them. One of the biggest fears for victims with children is that telling you will result in the children being taken into care. This is very unlikely to happen, particularly if the victim has disclosed this to you.
- Remember and acknowledge your own limitations – The individual may want to talk

to someone who can offer specific specialist advice.

- Always check if there are children in the household. Always document the children's details including full name and DOB. You must consider the needs of any children as paramount. Even when the victim refuses support, you have to consider the victim's ability to protect the children from abuse. It should be made clear at the outset that if you have any concerns about the welfare of children you have a duty to share that information to protect them. Seek advice from someone who may have more information about the family such as the Health Visitor, School Nurse or the Safeguarding Children Team. **(See Appendix 4 for contact details)**
- Health contact is always an opportunity to provided provide information on support services and signpost individuals if safe to do so even where domestic violence is not disclosed but suspected.

  Anyone affected by domestic abuse can contact:

  Lancashire-
  Victim Services on 0300 323 0085 or by emailing info@lancashirevictimservices.org
  Further information is available at www.lancashirevictimservices.org

  Cumbria -
  Victim Services on 0300 303 0157
  https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/north-west/cumbria

- Make sure the person knows how to contact you - this conversation may be just the beginning. They might not want to talk right now, but are now aware you are someone they could talk to in the future. Always ensure a Safeguarding Note is made on Lorenzo to allow colleagues to follow up at the next opportunity.

4.5 Routine Enquiry – Maternity Services

Routine enquiry and providing information and support requires the health professional to ask pregnant women if they are experiencing domestic abuse, whether or not they show any signs of it. Women should be asked about domestic abuse at every maternity contact if they are seen on their own both during pregnancy and once the baby has been born. If the woman is always accompanied at her antenatal appointments, the health professional must make an opportunity to see the woman alone at least twice during pregnancy and once in the post-natal period.

Recording of the routine enquiry question is done on Lorenzo and all maternity colleagues are aware of how to record that the question has been asked.

Health professionals should always remember that routine enquiry should never be seen as a one-off activity. Enquiry at every possible contact increases the likelihood of a woman feeling safe enough to talk about her abuse. Asking all women at these times helps avoid stigma and inappropriate judgements. It is essential that health professionals who are carrying out routine enquiry always have up to date information, such as leaflets or telephone numbers, available to them to offer the opportunity of alternative or more specialised advice.

Each situation is different, therefore there is no script of what to say that fits all occasions, however direct questioning is always best practice. If your messages are unclear then the woman may misinterpret your message and an opportunity for her to disclose to you may be lost. The key is confident questioning; if you don't feel confident about what to ask, discuss with more experienced colleagues and ask what they may do or say in these situations, or consider some of the examples listed here.

Suggested ways of making routine enquiry that you may find helpful:

- 'As part of your maternity care you will routinely be asked about domestic abuse because research informs us that 1 in 4 women face abuse in their home during their lifetime and this might occur for the first time in pregnancy. We ask so that we can give all women information about agencies that can help.'
- 'How is your relationship?'
- 'Do you ever feel unsafe at home?'
- 'Have you ever been afraid of your partner's or a family member's behaviour - are they verbally abusive?'
- 'Has your partner or anyone else, at home threatened you?'

Depending on the response a health professional receives, they may go on to ask:

- 'Have you ever been hurt by your partner or anyone else at home - perhaps slapped, kicked or punched?'
- 'Have you ever been forced to do something sexual that you didn't want to do?'
- 'Has your partner ever withheld money from you, leaving you unable to buy the necessities for you or your children?'
- 'Have you ever been prevented from leaving the house, or locked in a room?'

These routine questions can be tailored to reflect the types of issues with which women present, however whatever the response, the individual should be provided with or signposted to domestic abuse information. If individuals decline the information this should be documented and followed up as per policy.

Remember, although a woman may not disclose anything the first time she is asked, it shows that you understand the issues and it may give her confidence to disclose to you at a later date.

It is ok to be honest. If you think a woman has been abused, tell her that you are concerned for her and want to help. If you suspect abuse a possible opening could be:

'I notice that you have a number of injuries (i.e. cuts, bruises, burns) and I wondered if everything was alright in your relationship. We know that 1 in 4 women experience abuse at home.' **(See Appendix 4)**

4.6 Responding to a Disclosure

If a person discloses that they are being abused it is important to know what to do next. As a health professional your role is to:

- Provide support and information and refer them to relevant agencies and submit a Patient Safety Incident to the Safeguarding Team who, on receipt, can offer further

advice and support if required.

- Never assume that someone else will take care of domestic abuse issues**;** you may be the persons first and only contact.
- Focus on the person's safety and that of the children, if they have any.
- You may be required to perform a risk assessment which will inform your safety planning along with whether the threshold has been met for a statutory referral to Children or Adult's Social Care.

Never advise someone to leave their partner or to take any particular course of action as this is not your role. This could lead to problems including increased danger for the person and their children.

The risk of serious injury or murder escalates dramatically when a woman leaves an abusive relationship. Leaving immediately may not be the best option.

4.7 Provision of Information and Support

- With regard to Maternity - Explain the role of the Specialist Midwife and if the patient wishes to be contacted.
- Information should be available on local and national help lines whether or not domestic violence is disclosed.
- Ensure the person feels that you believe them, make it clear that the abuse is not their fault and that they have the right to safety.
- Let them know they are not alone
- Explain confidentiality - but be clear if you are worried about the risk of harm to self, children or to others, then you will need to share that information.
- Discuss with the person what will be documented in their records and who this information may be shared with; this could include her community midwife, school nurse, health visitor and general practitioner. Do not document DV in antenatal review.
- Do not act as a mediator between the victim and their abuser - this requires specialist assessment and skills and can be very dangerous to all concerned.
- Do not discuss the disclosure with the abuser or other family members.
- Plan for follow up care such as additional appointments or referral to a domestic abuse support worker.
- Obtain a phone number that is agreed with the victim on which it is safe to contact them. Agree whether messages can be left.

4.8 Assessing Risk

It is important to determine the level of risk and danger faced by the victim and their children. You do not have to assume full responsibility for this but you do play an important part, particularly when assessing if someone is at immediate risk of harm.

Never take on lone responsibility for dealing with high-risk situations. Support and guidance can be sought from the Specialist Midwife, Matron or site manager and the Safeguarding Team.

The UHMBT Safeguarding duty number is 01524 512425 (42425 internal) and can be contacted 9-5 Monday to Friday.

The person experiencing domestic abuse will usually be able to predict the risks they face and the likelihood of further abuse. However, health professionals should also be aware that they will often underestimate or minimise the risk of harm to themselves and their children. Where the risks are considered to be less immediate, it is advised to use the SafeLives Risk Indicator Checklist[11].

Assessing risk:

- If there is immediate risk from harm you should call the police on 999.
- Where a victim has already sustained injuries, a referral to Emergency Services, general practitioner or Emergency Department for treatment may be required.
- If the patient has parental or carers responsibility, a referral to Adult or Children's Social Care is required. Please always ensure you document full details of all dependants.
- Ensure personal safety of staff and others.
- Submit Patient Safety Incident (PSI) for information sharing and to ensure safeguarding and governance oversight.
- To ensure ongoing support and a multi-agency response, **with consent**, complete a Safe Lives risk assessment. **Risk Indicator Checklist**
- It is important to understand that a referral to MARAC **does not** require consent, and this can be made on the basis of professional judgement.

4.9 Safety Planning

Domestic abuse is significant in that it occurs repeatedly and is cyclical in nature, often with periods of calm interspersed with abusive behaviour. It is important that an individual who discloses abuse is encouraged to have a safety plan of what to do when the abuse starts. Many victims will know when abuse is likely to occur and can, to some degree, predict it. If victims are able to do this, they can be helped to think about what they can do to reduce the risks in emergency situations.

Safety planning needs to begin with an understanding of the victims' view on the risks to them and their children, and the strategies they have in place to address them. A key question is whether they intend to remain in the relationship with the abusive partner.

It is important that the plan is based on the individual's needs and predominantly the needs of any children and it may be more appropriate for workers from specialist domestic violence services to help do this.

Recognise and acknowledge the extent and limitations of your role - you may need to refer to a more specialist service for support **(see Appendix 3 - Domestic Violence Identified).**

Support can be accessed via the Trust Safeguarding Team duty number 01524 512425 (42425 internal).

4.9.1 What Should a Safety Plan Cover?

- Safety in the relationship.
- Places to avoid when the abuse starts e.g. the kitchen, where there is access to potential weapons.
- People a victim can turn to for help or let them know he/she is in danger.
- Asking friends or neighbours to call 999 if they hear anything that worries them.
- Places to hide important phone numbers.
- How to keep children safe when the abuse starts.
- Teaching children to find safety or get help, perhaps by calling 999.
- Keeping important documents in one place so they can be taken together in case of the need to leave suddenly.
- Letting someone know about the abuse so that it can be recorded.
- Leaving in an emergency.
- Packing an emergency bag and hiding it in a safe place.
- Plans for who to call and where to go.
- Remember to take documents, medication and keys.
- Access to a phone.
- Access to money.
- Plans for transport.
- Plans for taking clothes, toiletries and toys for the children.
- Taking proof of abuse.

4.9.2 Safety Considerations When a Relationship is Over

- Contact details for professionals.
- Changing land line and/or mobile telephone numbers.
- How to keep current location a secret from the abuser.
- Getting a Non-Molestation, Exclusion or Restraining Order.
- Talk to children about staying safe.
- Talk to employer for help with staying safe at work.

4.10 Responding to Police Domestic Violence Notification PVP (Protecting Vulnerable Person's report)

The police will notify both Children's Social Care and the Safeguarding Team when they have been called out to a domestic violence incident (Lancashire only) and it is found to involve any of the following:

- The victim or perpetrator is known to be pregnant.
- There is a child abuse marker on the address irrespective of the severity of the incident.
- A child under the age of 18 years is living/present in the household and/or the child has made the call for assistance.
- It is the third reported incident within the previous 12 months.
- The incident is so serious and the Officer feels or believes a referral should be made.

4.10.1 On Receipt of Notification, Midwifery Action as follows

The Safeguarding Team will review the notification and forward a copy to the Specialist Domestic Abuse Midwife.

- Specialist Domestic Abuse Midwife should check if the woman is already booked for care with the midwifery service, when her next appointment is - whether this in the community or hospital. The Specialist Midwife should consider if the case can wait until this appointment, or if the case requires a more immediate response. The Specialist Midwife will occasionally make a recommendation for an earlier review based on their understanding of the case or where the number of repeat incidents in a short period of time has been highlighted.
- Always consider each domestic violence incident in relation to severity, frequency and duration as this will indicate the length of time children have been exposed to a traumatic and abusive event.
- Review previous history/contact with the family to help determine the threshold for intervention and appropriate action.
- Consideration must be given to undertaking an assessment (e.g. Common Assessment Framework (CAF) or Early Help assessment; to determine level of risk to child/victim to assess needs of individual children).
- Consider liaising with Children's Social Care to ascertain whether they are involved or will be acting on the information.
- Not all incidents will require a follow up contact. Remember the police have attended this incident and should have addressed any immediate safety issues. Decisions whether or not to carry out a follow up visit should be clearly documented.
- Record the incident on the antenatal Summary Card and place notification in the case notes. Consider liaising with the Health Visitor, General Practitioner and school nurse where there is an older child in the family.

4.11 Making Contact with the Family

Where a decision has been taken to follow up the notification, consideration must be given to the following points:

- If there are pre-school and school age children in the family, discussion may take place between the Children's Centre, Health Visitor and School Nurse so as to determine how best to work together e.g. joint home visits, meeting mother at school etc.
- When arranging to see the mother alone at home, or other suitable venue, ensure that letters/cards are not sent detailing the reason for the visit. Even a telephone contact may be overheard. Unless you are sure of confidentiality do not specify the reason for the visit.
- Make sure you have considered a possible alternative reason for visiting in case the woman's partner or other family members are present, e.g. antenatal check, discuss antenatal screening, birth plan. Try to make another appointment to see her again.
- If a visit is planned, you may complete the SafeLives risk assessment[11] (see Appendix 2 and address safety planning and referrals as necessary.
- Check whether the children are subject to a CAF or Early Help. If not consider completing a CAF or Early Help in line with local procedures.

- Consider the possibility of a referral to the Multi Agency Risk Assessment Conference (MARAC). Referral will depend on outcome of the SafeLives risk assessment[11] and your professional judgement. Up to date criteria for referral to MARAC can be obtained from the Specialist Midwife Vulnerable Families Team or safeguarding team.
- If you consider that the child is at risk of significant harm then a referral to Children's Social Care must be made in line with local procedures.
- Document reasons for action and outcomes.

NB: Lone Visiting - When planning lone visits always consider your own personal safety. In cases where little is known about the family or home environment, contact at a venue other than home should be considered. If concerned, visit in two's and use Reliance Lone Worker device.

4.12 Confidentiality

It is vitally important that information on domestic violence and abuse is kept confidential. Without confidentiality, women are less likely to talk about their experiences. However it is essential to explain to women that there are limits to confidentiality, for example where there is reason to suspect children are at risk, safeguarding the children should always take precedence over confidentiality.

In cases of serious assault, it would be helpful to have the individuals consent to share information with another agency but, as with child protection and vulnerable adults the welfare of the victim is paramount (under section 115 of the Domestic Violence, Crime and Victims Act 2004[12], it is permissible to pass information to another agency where there is significant risk of harm to the woman or someone else if that information isn't passed on).

Extreme care should be taken to protect the safety of victims of abuse. No information must be disclosed that may breach their safety, i.e. a third party trying to find the whereabouts of children to trace a mother.

Where there are concerns about forced marriage or 'honour' based violence, some of the underlying principles and themes within existing guidance may inadvertently place young people and vulnerable adults at greater risk of harm. It is important that staff do not actively facilitate family counselling, mediation, arbitration or reconciliation as there have been cases of individuals being murdered by their families during mediation.

4.13 Information Sharing

The only acceptable reason for sharing information without consent is to increase the victims' safety and that of any children. It is important that all staff understand when, why and how they should share information so that they can do so confidently and appropriately. If in doubt, especially where the doubt relates to a concern about possible significant harm to a child or serious harm to others, advice must be sought from your line manager, or a member of the Safeguarding Team.

Where a decision is taken to share information, that information must be accurate and up-

to-date, necessary for the purpose for which it is being shared, shared only with those who need to see it, and shared securely. A record of the decision, including reasons for that decision, must be made - whether it is to share information or not.

For further detailed guidance access *Information sharing: Advice for safeguarding practitioners who provide safeguarding services to children, young people, parents and carers* (HM Government, July 2018)[13] at: https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

Concerns about a child: In all circumstances, where a child is considered to be at risk of harm, local child protection procedures must be followed in accordance with Safeguarding Children, Corp/Pol/021 (see section 6).

Concerns about serious harm to an adult: In circumstance where it is considered that an adult is at risk of serious harm contact the Police and raise a safeguarding adult concern with Adult Social Care as per Adults at Risk

See appendix 3 –Domestic Violence Contact Details.

4.14 Awareness and Training

Safeguarding competences are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice. These are governed by the Children's Safeguarding Intercollegiate Document 2019 and Adults Safeguarding Intercollegiate Document 2018.

Different staff groups require different levels of competence depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of responsibility. *Please read in conjunction with the Safeguarding Training Matrix.*

Safeguarding training is mandatory and is an individual responsibility to ensure that they remain updated. This is monitored through annual appraisals and the Trust TMS (Training Management System).

Refer to Safeguarding Intranet Matrix for Safeguarding requirement and to view the matrix https://nhscanl.sharepoint.com/sites/Safeguarding

4.15 Safeguarding Supervision

Supervision for practitioners is an essential component for maintaining safe and effective practice and this is included within safeguarding Supervision. Within UHMBT safeguarding supervision is provided by the Safeguarding Team, Named Nurses/Midwife and specially trained Safeguarding Children and Adult Supervisors. Supervision involves elements of reflection and case management and is available to all Trust staff either on a one to one basis or in a group setting. There may be times when practitioners require

additional support and supervisors would refer to their line managers for this.

4.16 Acknowledgements

This procedure has been adapted from the policy developed by Lancashire Teaching Hospitals NHS Foundation Trust with their permission.

5. ATTACHMENTS	
Number	**Title**
1	Criteria for MARAC
2	Safer Lives DASH Risk Checklist
3	Domestic Violence Identified
4	Domestic Violence Contact Details
5	Domestic Violence Antenatal Care Pathway
6	MARAC Referral Form
7	Domestic Abuse Referral Process to IDSVA
8	Values and Behaviours Framework
9	Equality and Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS The latest version of the documents listed below can all be found via the Trust Procedural Document Library intranet homepage.	
Unique Identifier	**Title and web links from the document library**
Corp/Pol/021	Safeguarding Children
Corp/Pol/021 (Attachment)	Safeguarding Children and Young People – Who To Tell
Corp/Pol/035	Adults at Risk
Corp/Sop/077	Safeguarding Operational Arrangements
Corp/Pol/014	Information Governance Policy and Framework
Corp/Pol/084	Safeguarding Supervision
Corp/Proc/015	Managing Allegations against Staff and Volunteers
Corp/Proc/081	Interpretation Services Procedure

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
No	**References**
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2	Cumbria Local Safeguarding Children Board (Cumbria LSCB) Domestic Abuse. [Online] Available at: http://www.cumbrialscb.com/professionals/domesticabuse/default.asp (accessed 6.2.20)
3	Pan-Lancashire and Cumbria Local Safeguarding Adult Board (LSAB) Domestic Violence and Abuse / MARAC. [Online] Available at: http://www.lancashiresafeguarding.org.uk/media/48734/Domestic-Abuse-

	Guidance.pdf (accessed 6.2.20)
4	Great Britain (2015) Serious Crime Act 2015. Available at: http://www.legislation.gov.uk/ukpga/2015/9/contents/enacted (accessed 6.2.20)
5	Great Britain (2002) Adoption and Children Act 2002. [Online] Available at: http://www.legislation.gov.uk/ukpga/2002/38/contents (accessed 6.2.20)
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7	Great Britain (2003) Female Genital Mutilation Act 2003. [Online] Available at: http://www.legislation.gov.uk/ukpga/2003/31/contents (accessed 6.2.20)
8	Home Office Circular 010/2004. The Female Genital Mutilation Act 2003. Available at: https://webarchive.nationalarchives.gov.uk/20130309162644/http://www.homeoffice.gov.uk/about-us/corporate-publications-strategy/home-office-circulars/circulars-2004/010-2004/ (accessed 6.2.20)
9	Home Office (2016) Domestic Violence Disclosure Scheme (DVDS) Guidance. Available at: https://www.gov.uk/government/collections/female-genital-mutilation-fgm-guidance-for-healthcare-staff (accessed 6.2.20) Home Office (updated 01/11/2019) Domestic Violence Disclosure Scheme fact sheet. Available at: https://www.gov.uk/government/publications/domestic-abuse-bill-2019-factsheets/domestic-violence-disclosure-scheme-fact-sheet (accessed 6.2.20)
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11	SafeLives Dash risk checklist. [Online] Available at: http://www.safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance.pdf (accessed 6.2.20)
12	Great Britain (2004) Domestic Violence, Crime and Victims Act 2004. [Online] Available at: http://www.legislation.gov.uk/ukpga/2004/28/contents (accessed 6.2.20)
13	Department of Education (2018) Information sharing: advice for safeguarding practitioners. [Online] Available at: https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice f (accessed 6.2.20)

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NICE Guidelines [CG110] (2010) Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. [Online] Available at: https://www.nice.org.uk/guidance/cg110 (accessed 6.2.20)
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MBRRACE-UK (2019) Saving Lives, Improving Mothers' Care: lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17 [Online] Available at: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/Saving%20Lives%20Improving%20Mothers%20Care%20report%202014%20Full.pdf (accessed 6.2.20)
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Department of Health and Social Care (2015) Female genital mutilation (FGM): resources for healthcare staff. Available at: https://www.gov.uk/government/collections/female-genital-mutilation-fgm-guidance-for-healthcare-staff (accessed 6.2.20)

8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
Child	A child is defined as anyone who has not reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is on further education, is a member of the armed forces, is in hospital or is in custody in the secure estate for children and young people does not change his or her status or entitlement to services or protection under the Children's Act 1989 (Working Together to Safeguard Children 2018, Children's Act 1989 / 2004
Child Protection Plan	The highest level of concern for a child's safety and wellbeing. It indicates that a multiagency decision has been made that the child is at risk of significant harm and a protective, supportive plan has been implemented.

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
	There is a statutory obligation for agencies to cooperate with the plan. A child with a plan will always have a social worker with responsibility for overseeing the plan.
Common Assessment Framework	An assessment undertaken when a child has additional needs that cannot be met by one agency alone. This work is overseen by a lead practitioner who may or may not be a social worker.
Early Help	Early help, also known as early intervention, is support given to a family when a problem first emerges. It can be provided at any stage in a child or young person's life.
Local Safeguarding Children Board	The local authority department responsible for any issues related to the safety and wellbeing of children. The local safeguarding boards can be accessed for guidance via the trust intranet.
Local Safeguarding Adult Board (LSAB)	The local authority department responsible for any issues related to the safety and wellbeing of vulnerable adults. The local safeguarding boards can be accessed for guidance via the trust intranet.
LSCB	Local Safeguarding Children Boards
LGBT	Lesbian, Gay, Bisexual, Transgender
Did Not Attend (DNA)	Did not attend appointment without cancellation. Also known as Was not Brought.
No Access Visit (NAV)	Not available at home to be seen for pre-arranged appointment.
MARAC	Multi Agency Risk Assessment Conference - Held every month, a number of key services are represented who gather and share information on 'high risk' domestic violence cases. Action plans are formulated with the view to improving the safety of victims, pursuing arrest and prosecution of perpetrators and reducing repeat offences. Anyone can refer a case to MARAC. Staff undertaking MARAC assessment and making a referral need to contact the Safeguarding Team, Named Nurse safeguarding adults or Named nurse/midwife safeguarding children so they can support the member of staff in making the referral and it being processed. Midwives making a referral should inform the Domestic Abuse Specialist Midwife as they attend the MARAC and can provide information and support to the midwife (see Appendix 1- Criteria for MARAC; Appendix 2 – SafeLives DASH Risk Checklist; and Appendix 6 - MARAC Referral Form).
CAF	Common Assessment Framework
IDVA	Independent Domestic Violence Advisor - Works with victims of domestic violence assessed as 'high risk', during or after the abusive relationship has ended. They provide specialised, intensive support and advice including safety planning and access to free legal services and support through the court system if required. They also provide health professionals with practical advice and support.
ISVA	Independent Sexual Violence Advisor
IDSVA	Independent Domestic and Sexual Violence Advisor

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
Support	Support for women can be arranged through Women's Aid in Appendix 3.

9. CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name/Meeting	**Job Title**	**Date Consulted**
Patricia Preston	UHMBT Domestic Violence Midwife	08/2019 01/2020
Safeguarding Team at UHMBT	CNS Sharon Taylor Named Nurse Adults Sarah Wright Named Nurse Midwifery Jane Heath	09/08/2019 10/10/2019 22/12/2019

10. DISTRIBUTION & COMMUNICATION PLAN	
Dissemination lead:	Safeguarding
Previous document already being used?	Yes
If yes, in what format and where?	Revised
Proposed action to retrieve out-of-date copies of the document:	Trust and Procedural Team will update
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Will be disseminated by SOPG members to Care Groups and uploaded to the Document Library

11. TRAINING

Is training required to be given due to the introduction of this procedural document? **Yes – continuous training**

If 'Yes', training is shown below:

Action by	Action required	To be completed (date)
Safeguarding Children and Adults Team	E- Learning - Induction Level 1 Children and Adults. Level 2 Children and Adults E- Learning. Face to Face Level 3 included E-Learning Level 3 - will be included in the Think Family training	Ongoing April 2020

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1.1	15/08/2017	Page 8	Last bullet point added to the Scope	01/11/2018
1.2	Oct 2017	Page 4	BSF Page Added	01/11/2018
1.3	06/07/2018	Appendix 6 Appendix 8	New MARAC referral form. IDSVA referral form removed (staff to use MARAC form).	01/11/2018
1.4	13/02/2019	Page 1	Review Date extended – form 025/2019	01/06/2019

1.5	07/06/2019	Page 1	Review Date extended – form 082/2019	01/10/2019
1.6	20/08/2019	Appendices 2,6,8	Replaced by links	01/10/2019
2	12/02/2020	Page 6	Definition updated	01/02/2023
		Page 6	Summary amended	
		Page 8	Links added	
		Page 10, Section 1.6	Amendments made to definition of Honour Based Violence	
		Page 11, Section 1.7	Domestic Violence Disclosure Scheme updated	
		Page 12	Reinforced message staff should never advise victim to leave	
		Page 14	Reference made to body maps	
		Page 15	Links updated	
		Page 16	Maternity Routine Enquiry updated	
		Page 19	UHMBT internal processes included	
2.1	06/03/2023	Page 1	Review Date extended – extension ID #806	01/05/2023
2.2	21/07/2023	Page 1	Review Date extended – extension ID #903	01/12/2023
2.3	27/10/2023	Page 1	Review Date extended – extension ID #978	01/02/2024

Appendix 1: Criteria for MARAC

- The threshold for MARAC for agencies using the SafeLives-DASH Risk Assessment is very high risk with **14** ticks on the Risk Indicator Checklist or where professional judgement warrants a MARAC referral.
- The threshold for MARAC for the police using the ACPO-DASH (Risk Assessment what is this?) model is based on professional judgement only or where three or more crime related incidents have been reported to the police in the last 12 months will get referred into the MARAC process.
- Repeat referrals get referred back in to the MARAC process if there is a further incident reported to at least one MARAC agency within a twelve month period of the last MARAC and that incident involves:
- Violence or threats of violence; and/or
- A pattern of stalking or harassment (the repeated following of communication with or other intrusions on the privacy of a victim) and or
- Where rape or sexual abuse is disclosed.
- (Multiple incidents occurring between MARAC meetings only result in one repeat MARAC referral)

The following do not constitute a repeat case:

- Where a case is reviewed at the MARAC involving the same victim but a different perpetrator or group of perpetrators.
- Where a case is reviewed at the MARAC involving the same perpetrator but a different victim.
- Where an incident not involving criminal behaviour occurs and is therefore not reviewed at MARAC.
- Where the same combination of victim and perpetrator is involved but being reviewed at a MARAC outside of the Lancashire Force Area. This is clearly a repeat incident in human terms however will not be recorded as such for the purposes of the indicator.
- Cases which are discussed at a MARAC meeting but for information purposes only (e.g. imminent release of perpetrator from prison; perpetrator begins CDVP)
- Cases which were previously reviewed at the MARAC more than 12 months ago.

Referral

- Agencies should refer cases to the MARAC using the MARAC referral form. The referral form needs to include as much information as possible including the name, date of birth, and address of victim, perpetrator and children. See Appendix 4 for a Copy of MARAC Referral Form.
- The MARAC operates a rolling referral system and cases are listed to the nearest available MARAC. The MARAC meets either on a monthly or fortnightly basis depending on the area.
- The MARAC Coordinator will circulate in advance referral deadline dates for all MARAC areas. The MARAC member should ensure they adhere to the dates set. Late referrals will be heard at the discretion of the chair however this will be the exception not the rule as other members need the allocated time to research cases. All referrals should be emailed to:
  MARAC Lancashire maracreferrals@lancashire.pnn.police.uk
  MARAC Cumbria maracreferrals@cumbria.ppn.police.uk

Appendix 2: SafeLives DASH Risk Checklist

SafeLives Dash risk checklist for use by IDVAs and other non-police agencies[1] for MARAC case identification when domestic abuse, 'honour'-based violence and/or stalking are disclosed.

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. **Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.** **It is assumed that your main source of information is the victim. If this is <u>not the case</u>, please indicate in the right hand column**	**YES**	**NO**	**DON' T KNOW**	**State source of info if not the victim** (eg police officer)
1. Has the current incident resulted in injury? Please state what and whether this is the first injury.	☐	☐	☐	
2. Are you very frightened? **Comment:**	☐	☐	☐	
3. What are you afraid of? Is it further injury or violence? Please give an indication of what you think [name of abuser(s)] might do and to whom, including children. **Comment:**	☐	☐	☐	
4. Do you feel isolated from family/friends? Does [name of abuser(s)] try to stop you from seeing friends/family/doctor or others? **Comment:**	☐	☐	☐	
5. Are you feeling depressed or having suicidal thoughts?	☐	☐	☐	
6. Have you separated or tried to separate from [name of abuser(s)] within the past year?	☐	☐	☐	
7. Is there conflict over child contact?	☐	☐	☐	
8. Does [name of abuser(s)] constantly text, call, contact, follow, stalk or harass you? Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.	☐	☐	☐	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	☐	☐	☐	
10. Is the abuse happening more often?	☐	☐	☐	
11. Is the abuse getting worse?	☐	☐	☐	
12. Does [name of abuser(s)] try to control everything you do and/or are they excessively jealous? For example: in terms of relationships; who you see; being 'policed' at home; telling you what to wear. Consider 'honour'-based violence (HBV) and specify behaviour.	☐	☐	☐	
13. Has [name of abuser(s)] ever used weapons or objects to hurt you?	☐	☐	☐	
14. Has [name of abuser(s)] ever threatened to kill you or someone else and you believed them? If yes, tick who: *You* ☐ *Children* ☐ *Other (please specify)* ☐	☐	☐	☐	

[1] This checklist is consistent with the Association of Chief Police Officers (ACPO) endorsed risk assessment model DASH 2009 for the police service.

15. Has [name of abuser(s)] ever attempted to strangle / choke / suffocate / drown you?	☐	☐	☐	
Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.	**YES**	**NO**	**DON' T KNOW**	**State source of info if not the victim**
16. Does [name of abuser(s)] do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? If someone else, specify who.	☐	☐	☐	
17. Is there any other person who has threatened you or who you are afraid of? If yes, please specify whom and why. Consider extended family if HBV.	☐	☐	☐	
18. Do you know if [name of abuser(s)] has hurt anyone else? Consider HBV. Please specify whom, including the children, siblings or elderly relatives: *Children* ☐ *Another family member* ☐ *Someone from a previous relationship* ☐ *Other (please specify)* ☐	☐	☐	☐	
19. Has [name of abuser(s)] ever mistreated an animal or the family pet?	☐	☐	☐	
20. Are there any financial issues? For example, are you dependent on [name of abuser(s)] for money/have they recently lost their job/other financial issues?	☐	☐	☐	
21. Has [name of abuser(s)] had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? If yes, please specify which and give relevant details if known. *Drugs* ☐ *Alcohol* ☐ *Mental health* ☐	☐	☐	☐	
22. Has [name of abuser(s)] ever threatened or attempted suicide?	☐	☐	☐	
23. Has [name of abuser(s)] ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? You may wish to consider this in relation to an ex-partner of the perpetrator if relevant. *Bail conditions* ☐ *Non Molestation/Occupation Order* ☐ *Child contact arrangements* ☐ *Forced Marriage Protection Order* ☐ *Other* ☐	☐	☐	☐	
24. Do you know if [name of abuser(s)] has ever been in trouble with the police or has a criminal history? If yes, please specify: *Domestic abuse* ☐ *Sexual violence* ☐ *Other violence* ☐ *Other* ☐	☐	☐	☐	
Total 'yes' responses				

For consideration by professional

Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural / language barriers, 'honour'- based systems, geographic isolation and minimisation. Are they willing to engage with your service? Describe.	
Consider abuser's occupation / interests. Could this give them unique access to weapons? Describe.	
What are the victim's greatest priorities to address their safety?	

Do you believe that there are reasonable grounds for referring this case to MARAC?		Yes ☐ No ☐	
If yes, have you made a referral?		Yes ☐ No ☐	
Signed		Date	
Do you believe that there are risks facing the children in the family?		Yes ☐ No ☐	
If yes, please confirm if you have made a referral to safeguard the children?	Yes ☐ No ☐	Date referral made	
Signed		Date	
Name			

Practitioner's notes

This document reflects work undertaken by SafeLives in partnership with Laura Richards, Consultant Violence Adviser to ACPO. We would like to thank Advance, Blackburn with Darwen Women's Aid and Berkshire East Family Safety Unit and all the partners of the Blackpool MARAC for their contribution in piloting the revised checklist without which we could not have amended the original SafeLives risk identification checklist. We are very grateful to Elizabeth Hall of CAFCASS and Neil Blacklock of Respect for their advice and encouragement and for the expert input we received from Jan Pickles, Dr Amanda Robinson and Jasvinder Sanghera.

Resource: Severity of Abuse Grid[2]

This Severity of Abuse Grid (SOAG) has been developed to be used with the Risk Identification Checklist. It gives you a framework within which you can identify specific features of the abuse suffered by your client and help you to address their safety in an informed and coherent way. It will also typically provide information that will be relevant for those cases going to MARAC.

To complete the SOAG, take the answers from the relevant questions on the checklist and then explore in more detail the severity of each category of abuse **currently suffered** and the escalation if it exists. Whether you are using it at the initial assessment or when reviewing risk, we recommend that the timeframe that should be applied for 'current' abuse is an incident within the last three months. Please note that each case is unique and you will have to use your professional judgement in relation to the information that you are given by your client. **The context in which these and similar behaviours occur is all important in identifying a level of severity.**

If you answer 'yes' to any of the questions 'is the abuse occurring?' you must circle one answer for each of the boxes in the other three columns to identify the level of severity, the escalation in severity and in frequency.

[2] Grid and guidance reproduced with kind permission of the Hestia Fund.

Type of abuse	Is abuse occurring?	Severity of abuse	Escalation in severity (past 3 months)	Escalation in frequency (past 3 months)
Physical	Yes No Don't know Not answered	High Moderate Standard	Worse Unchanged Reduced	Worse Unchanged Reduced
Sexual	Yes No Don't know Not answered	High Moderate Standard	Worse Unchanged Reduced	Worse Unchanged Reduced
Stalking and harassment	Yes No Don't know Not answered	High Moderate Standard	Worse Unchanged Reduced	Worse Unchanged Reduced
Jealous and controlling behaviour / emotional abuse	Yes No Don't know Not answered	High Moderate Standard	Worse Unchanged Reduced	Worse Unchanged Reduced

Guidance on completing the Severity of Abuse Grid

Note: This guidance is designed to help you complete the SOAG above. Please note that each case is unique and you will have to use your professional judgement in relation to the information that you are given by your client.

The context in which these and similar behaviours occur is all important in identifying a level of severity. For example, the misuse of substances including alcohol may increase the level of risk faced by an individual. Similarly, the cultural context in which abuse takes place should inform your judgement as to the level of risk posed.

Physical abuse			
No	Standard	Moderate	High
Never, or not currently	Slapping, pushing; no injuries.	Slapping, pushing; lasting pain or mild, light bruising or shallow cuts.	Noticeable bruising, lacerations, pain, severe contusions, burns, broken bones, threats and attempts to kill partner, children, relatives or pets. Strangulation, holding under water or threat to use or use of weapons, loss of consciousness, head injury, internal injury, permanent injury, miscarriage.
Sexual abuse			
No	Standard	Moderate	High
Never, or not currently	Use of sexual insults.	Uses pressure to obtain sex; unwanted touching, non-violent acts that make victim feel uncomfortable about sex, their gender identity or sexual orientation.	Uses threats or force to obtain sex, rape, serious sexual assaults. Deliberately inflicts pain during sex, combines sex and violence including weapons, sexually abuses children and forces partner to watch, enforced prostitution, intentional transmission of STIs/HIV/AIDS.
Harassment or stalking			
No	Standard	Moderate	High
Never or not currently	Occasional phone calls, texts and emails.	Frequent phone calls, texts, emails.	Constant/obsessive phone calls, texts or emails, uninvited visits to home, workplace etc or loitering. Destroys or vandalises property, pursues victim after separation, stalking, threats of suicide/homicide to victim and other family members, threats of sexual violence, involvement of others in the stalking behaviour.
Jealous or controlling behaviour/emotional abuse			
No	Standard	Moderate	High
Never or not currently	Made to account for victim's time, some isolation from family/friends or support network, put down in public.	Increased control over victim's time, significant isolation from family and friends, intercepting mail or phone calls, controls access to money, irrational accusations of infidelity, constant criticism of role as partner/wife/mother.	Controls most or all of victim's daily activities, prevention from taking medication, accessing care needs (especially relevant for survivors with disabilities); extreme dominance, e.g. believes absolutely entitled to partner, partner's services, obedience, loyalty no matter what. Extreme jealousy, e.g. 'If I can't have you, no-one can', with belief that abuser will act on this. Locks person up or severely restricts their movements, threats to take the children. Suicide/homicide threats, involvement of wider family members, crimes in the name of 'honour'. Threats to expose sexual activity to family members, religious or local community via photos, online (e.g. Facebook) or in public places.

Appendix 3: Domestic Violence Identified

Actual/Potential Domestic violence disclosed
(Following discussion with patient/victim, document on electronic patient record only

Enquire about patient/victim's & dependents safety. If immediate risk – contact Police 999

- Assess – safety
- Listen – support
- Complete Risk Assessment SafeLives DASH
- Adult or Child Safeguarding referral if indicated
- Refer to appropriate agencies – H/V GP, MARAC Police, Children's services, SOM, Matron
- Discuss with Manager Safeguarding Team
- Complete PSI

- Give details of support available and how to seek help. Ensure victim knows they can speak confidentially to a professional.
- Discuss follow up visit. Arrange where and when to suit needs of the patient/victim – i.e. at GP surgery, hospital ante-natal clinic or Children's Centre
- Discuss disclosure of information to school nurse, health visitor, general practitioner and any other agencies involved
- If child protection issues identified, follow Trust Safeguarding Policy.

If not safe to go home

Safe for victim to stay with family or friends?

Short-term admission to hospital necessary

Requires a place at a refuge

Wishes the police to be informed

Domestic Violence Helpline (24 hour line): 0808 2000 247

Men's Advice Line (for male victims of domestic abuse): 0808 801 0327

Local Victim Support 0300 323 0085 Lancashire
Local Victim Support 0300 303 0157 Cumbria

National Victim Support 0845 3030 900

Empowerment (refuge database): 0300 323 2100 (option 6)

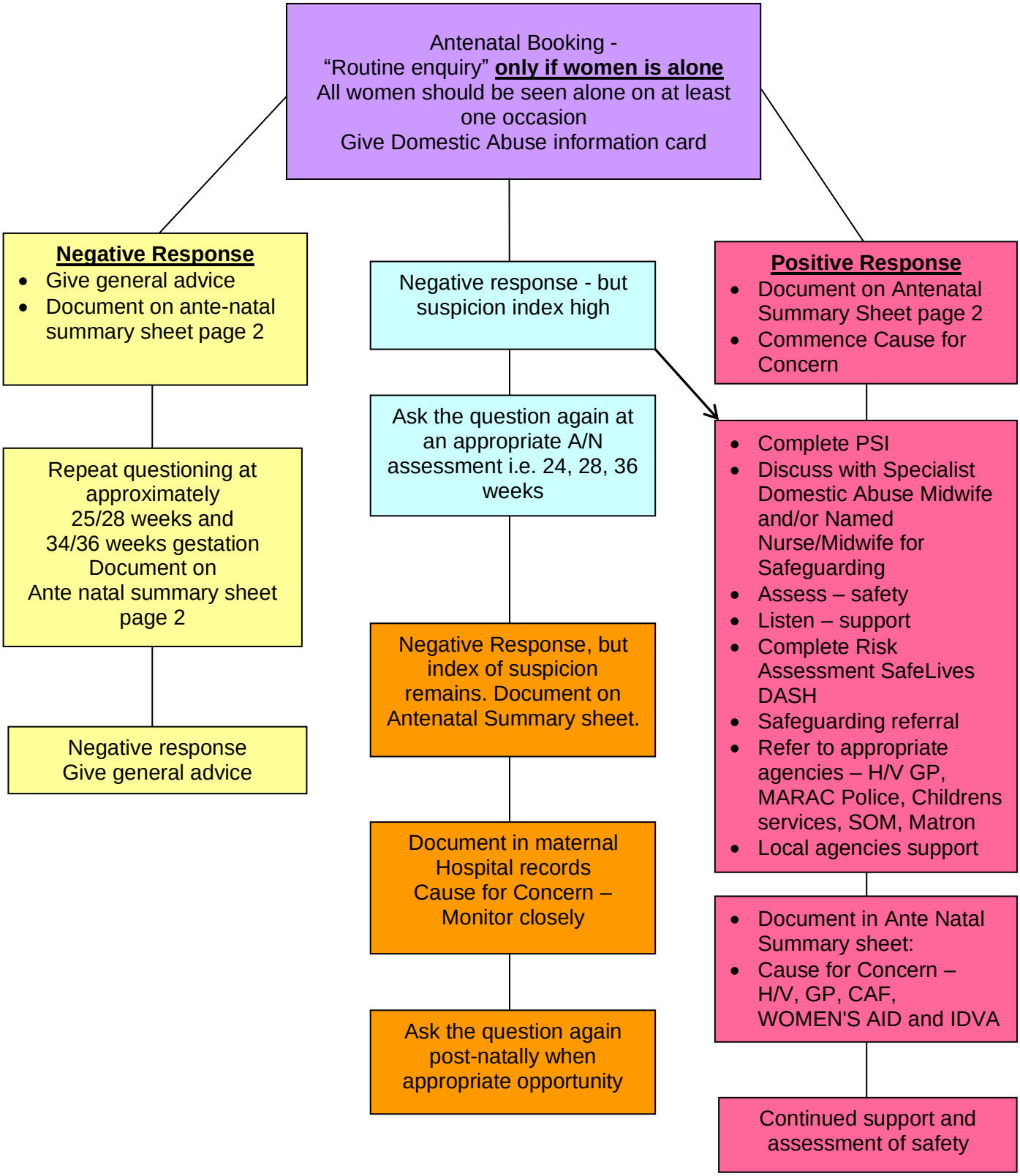
Springboard South Lakeland (offers support & counselling for people affected by domestic abuse): 01539 742624

Ring 999 if immediate danger Or 101 which puts you through to the Police Communications Room if no immediate concerns

Appendix 4: Domestic Violence Contact Details

Organisation	Department	Contact Number(s)
University Hospitals of Morecambe Bay NHS Foundation Trust	Domestic Violence Specialist Midwife	07776 245648 Community Midwives Office 01524 583867
	Safeguarding team (via the duty safeguarding nurse)	01524 512425
Children's Social Care	Lancashire	0300 123 6720
	Lancashire Out of Hours	0300 123 6722
	Cumbria Safeguarding Hub	0333 240 1727
Police	All Domestic Violence Units can be accessed by telephoning 101	999 if an emergency
MARAC	Lancashire Co-ordinator	01772 412771 or 01772 413686
MARAC	Cumbria Co-ordinator	07528 966 602 or 07528 966 601
IDVA and ISVA Service	Cumbria Victim Support	0300 303 0157
IDVA and ISVA Service	Lancashire Victim Support	0300 323 0085

Appendix 5: Domestic Violence Antenatal Care Pathway



Appendix 6: MARAC Referral Form

Ending domestic abuse

Lancashire MARAC Referral form

--- MARAC Referrals should be sent by a secure email or other secure method ---

Important Information, please read before completing this form:
This form, when completed will contain personal information (data) including special category (sensitive) data. You are required to comply with **General Data Protection Regulations** in the processing (including storage & retention) of this data. Please refer to your internal Data Protection Policy; local Marac Operating & Information Sharing Protocols The GDPR and The Data Protection Act 2018. Article 5 of the GDPR sets out seven key principles which lie at the heart of the general data protection regime. These principles should lie at the heart of your approach to processing personal data.

It is the responsibility of the referring agency to comply with GDPR and the seven key principles. Compliance with the spirit of these key principles is a fundamental building block for good data protection practice. It is also key to your compliance with the detailed provisions of the GPDR. Failure to comply with the principles may leave you open to substantial fines.

The purpose of a Marac referral form is to provide only the relevant information required to enable the Marac administrative team to process the personal data and information necessary to populate an accurate agenda to be sent to the relevant agencies listed within the Marac Operating Protocol (MOP), and to maintain accurate records as agreed within the MOP. A separate referral with additional information will need to be completed for referral to Idva.

Referring Agency Referring agency is *required* to attend Marac meeting to present case, if this is not possible please provide details of the agency representative who will attend & present case on your behalf			
Contact Name(s)			
Telephone / Email			
Date			
Victim Name		**Victim DOB**	
Address			
Telephone Number		**Is this number safe to call?**	YES / NO
Please Add Any Relevant Contact Information. (e.g. best times to call)			
Diversity Data (If Known)	B&ME ☐ Disabled ☐ LGBT ☐ V u18 ☐ P u18 ☐ Gender M / F		

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**

Reason for referral / additional information

Professional Judgement	YES / NO	**Visible High Risk (*14 ticks or more on SafeLives - DASH RIC*)**	YES / NO
Potential Escalation (*3 or more incidents reported to the Police in the past 12 months*)	YES / NO	**MARAC Repeat (further incident identified within twelve months from the date of the last referral)**	YES / NO
If it's a YES for the MARAC Repeat, Please provide the Date listed / Case Number (if known)			
Is the victim aware of MARAC referral?	YES / NO	**If NO, why not?**	
Has the victim been referred to any other MARAC previously?	YES / NO	**If YES where / when?**	
Has consent been given?	YES / NO		
Under what condition (Art 9(2) GDPR) is special category data shared? Please detail.	YES / NO		
Who is the Victim afraid of? (To include all potential threats, and not just primary perpetrator)			
Who does the Victim believe it IS safe to talk to?			
Who does the Victim believe it is NOT safe to talk to?			

Details of the incident which has resulted in MARAC Referral **Reason for referral & lawful basis for sharing this information (consider relevancy, proportionality & whether the information provided is necessary for the purpose of this referral form)** It is the **responsibility of the referring agency to be satisfied that the threshold for Marac is reached** (that the victim of domestic abuse is at high risk of serious harm or homicide). It is not necessary for the purpose of this Marac referral form to share details here. It is, however, important to indicate under which criteria the threshold is met:		
Date of Incident	**Risk Assessment Score**	**Circumstances (Please provide only the MOST RELEVANT and CURRENT RISK details. Anything after 12 months of the date of this referral is not required and could be discussed within the MARAC meeting)**

PLEASE NOTE: YOU ARE THE LEAD REFERRER FOR THIS REFERRAL AND AS SUCH, YOU ARE ACCOUNTABLE FOR ENSURING THAT THE MOST APPROPRIATE ACTIONS HAVE BEEN UNDERTAKEN TO ADDRESS THE RISK(S) YOU HAVE HIGHLIGHTED.	
Date	**Detail YOUR own action(s) / involvement to safeguard the victim, also please specify if any Police involvement has been undertaken to address the risks highlighted and any specific Police Log Ref numbers.**

Has this referral been sent to the relevant IDVA service?	
Has this referral been sent via your MARAC representative?	

Information for victims referred to MARAC

The victim's safety should be at the centre of the MARAC. Keeping a clear focus on safety is easier when the victim is engaged in the process and their views are represented at the meeting. Normally the IDVA is best placed to do this by both contacting the victim before and updating the victim after the meeting (where it is safe to do so), in addition to liaising with partner agencies. The referring agency should usually inform the victim of MARAC referral where it is safe to do so. This may be done by letter if there has been an incident of public record (e.g. reported to the police). If the perpetrator is unaware that the victim has sought help in relation to domestic abuse then it may be safer to discuss the referral by phone or in person (e.g. disclosures to a midwife).

To supplement these contacts, local areas often produce information for victims referred to the MARAC. In some cases a 'Leaflet Informing the Victim of the MARAC' is provided to the victim on referral where it is safe to do so.

Leaflet informing victims of the MARAC

This might contain:

Definition of a MARAC, including:

- What is the purpose of the MARAC
- Who is referred to the MARAC
- Which agencies would normally attend the MARAC
- How the victim is represented at the MARAC
- The role of the IDVA and how victims can contact them

Confidentiality at the MARAC:

- Define what is meant by confidentiality
- Identify exceptions to confidentiality, including links to Safeguarding Children and Adults

What happens after the MARAC:

- What kind of actions might come from the MARAC
- How will the MARAC help the client

Contact details for IDVA service and local police

Useful contact numbers for your local area and websites

Name of victim
Address of victim

Date

Dear Ms/Mr ABC

You have been referred to the [insert area name] MARAC, because we believe that you are at high risk of current or future harm because of domestic abuse. Domestic abuse is defined[1] as 'any incident of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality.' It can include honour based violence, female genital mutilation, and forced marriage.

The Multi-Agency Risk Assessment Conference (MARAC) is a meeting that brings together representatives from a number of agencies in the area (both statutory and voluntary) to talk about the safety, health and well-being of people experiencing domestic abuse (and their children) and draw up an action plan to make them safer.

Your case has been referred to the MARAC by [insert name of agency] because you have been identified as being at risk of current or future harm from domestic abuse. Normally this is because of the things that an abuser is doing or the things they are saying they will do. By referring you to the MARAC, we are trying to make you safer by working with other agencies to get help and support. We hope that you will support this process as with your involvement we can be best placed to address your safety concerns.

Anyone referred to the MARAC is offered support by an IDVA (Independent Domestic Violence Advisor) from [insert area name]. The IDVA's role at the MARAC is to represent your views, act as link between agencies and to ensure that any actions agencies take will make you safer. Ahead of a meeting, they will contact you to talk about your situation, what would make you feel safer and identify any issues that you think should be addressed at the meeting. Usually, they (or sometimes another professional who you know) will contact you to provide feedback about the meeting. You do not attend the meeting yourself, but are represented. Practitioners from a range of statutory or voluntary agencies attend. There is also a protocol between agencies participating in the MARAC which makes it clear what is expected of individual agencies, including how to store, manage and share any information they gain from the MARAC.

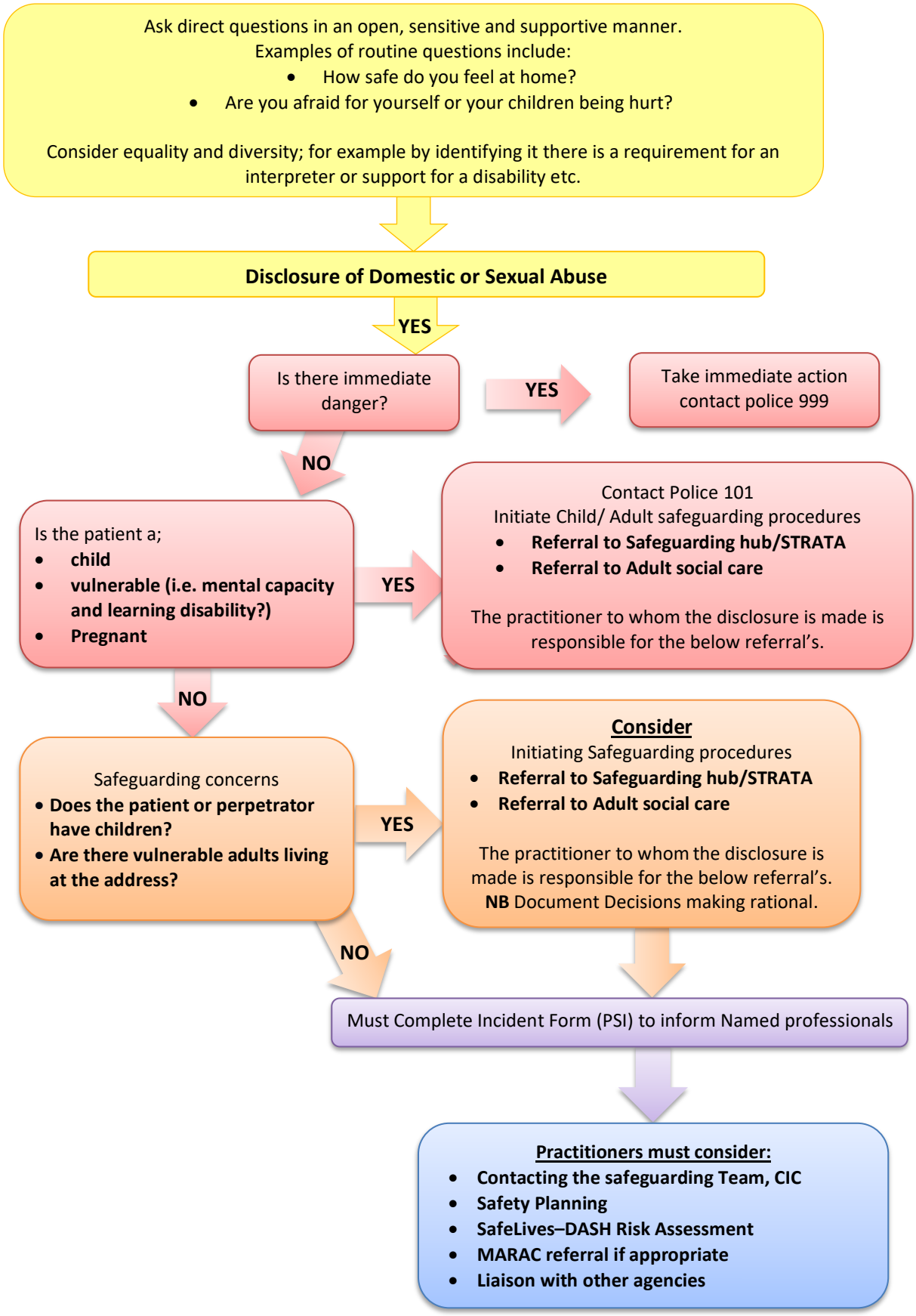
We work with many local organizations' that may also be able to provide you with help and advice. I am enclosing a list of useful telephone numbers with details of some of these groups.

Yours sincerely,

MARAC Chair

LINK to Cumbria MARAC referral Forms Multi-Agency Risk Assessment Conference - cumbria.police.uk

Appendix 7: Domestic Abuse referral Process



Appendix 8: Values and Behaviours Framework

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a positive workplace culture. By following our own policies and with our **ambitious** drive we can cultivate an **open, honest and transparent culture** that is truly **respectful and inclusive** and where we are **compassionate** towards each other.

Appendix 9: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Safeguarding		
Lead Assessor	Liz Thompson		
What is being assessed?	Revised Domestic Abuse – Guidance and Procedures		
Date of assessment	28/01/2020		
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Network	○ Yes	◉ No
	Staff Side Colleague	○ Yes	◉ No
	Service Users	○ Yes	◉ No
	Staff Inclusion Network(s)	○ Yes	◉ No
	Personal Fair Diverse Champions	○ Yes	◉ No
	Other (including external organisations) Please give details:	◉ Yes	○ No

1) What is the impact on the following equality groups?		
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	

Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.