NHS
Somerset
Clinical Commissioning Group

DOMESTIC ABUSE POLICY

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DOMESTIC ABUSE POLICY

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DOMESTIC ABUSE POLICY

1 INTRODUCTION

1.1 This policy reflects local, national, strategic and operational guidance in response to the growing recognition of the detrimental effects that domestic abuse has on society as a whole. It demonstrates the principle that domestic abuse is behaviour that should not be accepted 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 that may have greater experience of domestic abuse in order to reduce the risk of harm to victims.

1.1 In 2017 the government was elected with a manifesto commitment to introduce a landmark Domestic Abuse Bill to transform the approach of the justice system and wider statutory agencies. The Bill aims to ensure that victims have the confidence to come forward and report their experiences, safe in the knowledge that the state will do everything it can, both to support them and their children and pursue the abuser. The manifesto included specific commitments to provide for a statutory definition of domestic abuse, establish a Domestic Abuse Commissioner and strengthen civil protection orders.

1.2 A draft Domestic Abuse Bill was announced in the June 2017 Queen's speech and the Domestic Abuse Commissioner role commenced in 2019, key priorities for the commissioner will be to raise public awareness, monitor the response of local authorities, the justice system and other statutory agencies and hold them to account in tackling domestic abuse.

1.3 In the year ending March 2018, an estimated 2.0 million children and adults aged 16 to 59yrs experienced domestic abuse in the last year (1.3 million women and 695,000 men).

1.4 Domestic violence and abuse is a volume crime, affecting one in three women and one in six men in their lifetimes. It accounts for 14% of violent crime, covering offences ranging from common assault to rape and murder. It has devastating consequences for the individual victim, their children and the wider society.

1.5 Statistics indicate that domestic violence and abuse is a gendered crime whilst both men and women may experience incidents of interpersonal violence and abuse, women are considerably more likely to experience repeated and severe forms of abuse, including sexual violence.

1.6 Every week in the UK, two women are murdered by a partner or ex-partner.

1.7 Domestic violence and abuse in male victims is a seriously underreported crime. The fear of failing to live up to masculine ideals is a significant barrier to accessing appropriate support.

2. POLICY STATEMENT

2.1 Somerset CCG recognises the detrimental effect that domestic abuse has on society, and upholds the value that everyone has a right to live free from fear and abuse.

2.2 As both employer, NHS body and clinical commissioner, Somerset CCG has a crucial contribution to make in the drive to address domestic violence and abuse.

2.3 Guidance produced by the Department of Health (www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals) has established domestic abuse as a major concern for all health care professionals and identifies the NHS as the one service that almost all victims of domestic abuse come into contact with regularly within their lifetime (either as their first or only point of contact with professionals).

2.4 The guidance recognises that the NHS spends more time dealing with the impact of violence against women and children than any other agency, and states that there is a strong need to improve health commissioning of universal and specialist services to interrupt perpetrators and support victims of domestic abuse, including children who are in the household.

2.5 The National Institute for Health Care and Excellence (NICE guidance), issued the PH50 Domestic Violence and Abuse Multi-Agency Response https://www.nice.org.uk/guidance/ph50 in February 2014 with further guidance detailing high priority areas in the Domestic Violence and Abuse Quality Standard: https://www.nice.org.uk/guidance/qs116 in February 2016.

2.6 The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in the planning and delivery of services, as part of a general duty to secure a continuous improvement in quality.

2.7 Somerset CCG is committed to driving measurable improvements across the health economy by promoting the implementation of the NICE PH50 Guidance and Quality Standard for domestic violence and abuse.

2.8 Implementation of this quality standard, in conjunction with the guidance of which it is based contributes to the improvements detailed in the outcomes framework published by the Department of Health:

- **Public Health Outcomes Framework 2016-2019 https://www.gov.uk/government/publications/public-health-outcomes-framework-2016-to-2019**

- **Adult Social Care Outcomes Framework 2018-19https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions**

2.9 Somerset CCG is committed to ensuring that people experiencing or perpetrating domestic violence and abuse receive a high standard of care irrespective of age, race, gender, sexual orientation, religion or ability with equality underpinning all service provision.

3. SCOPE

3.1 This document applies to all staff and all services within Somerset Clinical Commissioning Group (CCG).

4. PURPOSE

4.1 To promote a consistent, measurable and effective approach to all domestic abuse related incidents through the implementation of the underpinning principles of the domestic violence and abuse multi-agency working (PH50) NICE guidance and the accompanying 4 quality statements of the domestic abuse NICE quality standard, (2016).

- Evidence of: local arrangements to ensure that people presenting to frontline staff with indicators of domestic abuse are asked about their experience in a private discussion.

- Evidence of: local arrangements to ensure that staff are trained to deliver a universal level 1 or 2 response to domestic violence and abuse.

- Evidence of: appropriate risk assessment and referral pathways to ensure that people experiencing domestic violence and abuse receive specialist support.

- Evidence of: assessment and referral pathways to ensure that people who disclose that they are perpetrating domestic violence and abuse are referred to specialist services

5. GUIDING PRINCIPLES

5.1 This guidance aims to help identify, prevent and reduce domestic violence and abuse. By providing a person-centred, integrated approach in delivering high-quality care to people experiencing or perpetrating domestic violence and abuse.

5.2 The core principles of the policy promote the importance of considering the intended or unintended consequences of domestic abuse on the entire family, “Think Family”. It is thus vital to consider that it is “Always” abusive to be part of a family where domestic abuse is present, whether witnessed or not. Exposure to domestic abuse can negatively impact the emotional well-being and development of children, and may lead to a failure to protect and safeguard children from harm.

6. ROLES AND RESPONSIBILITIES

6.1 GOVERNING BODY

- To explicitly state the CCG's commitment to the early detection and prevention of domestic abuse.

- To ensure that the CCG develops and implements clear strategies, structures, policies and procedures to ensure that children and adults experiencing or at risk of abuse and neglect are safeguarded and that the commissioned provider services comply with relevant national legislation to discharge their duties effectively.

- To ensure effective partnership working for the reduction of domestic abuse.

6.2 PATIENT SAFETY AND QUALITY ASSURANCE & COMMITTEE

- As the designated Board committee with responsibility for seeking assurance and challenging matters of safety, the committee is responsible for;

- Receiving assurance reporting

- Providing scrutiny and challenge

- Receiving reports from the health representative at the Safer Somerset Partnership strategic board, and its associated boards, for example: Somerset Domestic Abuse Board.

6.3 THE CCG SAFEGUARDING ADULTS & CHILDRENS TEAM

- This includes the Designated Professionals for Safeguarding Children & Adults (including Children Looked After and Child Death Designated Professionals)

- To facilitate adherence to the CCG Domestic Abuse policy, including relevant domestic abuse elements of the Children and Adults safeguarding policies.

- To provide leadership and guidance, in the reduction of domestic abuse by promoting the implementation of systems and processes that support early detection and prevention.

6.4 SOMERSET CCG EMPLOYEES

- All employees should*:*

- Be aware of the extent and impact of domestic violence and abuse and understand the significant overlap between domestic abuse within both child and adult safeguarding.

- Understand that they have a responsibility to recognise domestic violence and abuse and take action to respond accordingly. Taking into account the individual's needs and wishes wherever possible

7. DEFINITION

7.1 The Home Office official definition, (2015) of domestic abuse:

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:

- Physical or sexual abuse
- Violent or threatening behaviour
- Controlling or coercive behaviour
- Financial abuse
- Psychological, emotional or other abuse

The definition includes issues such as so called 'honour based violence' (HBV), female genital mutilation (FGM) and forced marriage (FM).

Family members are defined as mother, father, son, daughter, brother, sister, and grandparents, whether directly related, in laws or stepfamily.

7.2 The Serious Crime Act 2015, recognises that non-violent coercive behaviour, a long-term campaign of abuse, often at the heart of domestic abuse and requiring the victim to fear the immediate application of unlawful violence is a serious crime. The act explicitly criminalises patterns of coercive or controlling behaviour where they are perpetrated against an intimate partner or family member.

7.3 It is important to recognise that domestic homicides can occur without prior patterns of physical violence. Domestic abuse is characterised by patterns of power and control; often with one party exuding a significant sense of entitlement and inordinate levels of control; using coercion and threats, intimidation, emotional abuse, and isolation to control their victim.

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

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

7.6 Financial abuse means any behavior that has a substantial adverse effect on one's ability to acquire, use or maintain money or other property, or obtain goods or services.

7.7 This definition includes 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

8. HONOUR BASED VIOLENCE

8.1 Honour Based Violence (HBV) is a term used to describe violence committed within the context of the extended family which are motivated by a perceived need to restore standing within the community, which is presumed to have been lost through the behaviour of the victim. Most victims of HBV are women or girls, although men may also be at risk.

8.2 Women and girls may be perceived to lose honour through expressions of autonomy, particularly if this autonomy occurs within the area of sexuality. Men may be targeted either by the family of a woman who they are believed to have 'dishonoured', in which case both parties may be at risk, or by their own family if they are believed to be either Lesbian, gay, bisexual, transgender, questioning (LGBTq)

8.3 Honour based violence and abuse can take many forms, e.g. threatening behavior, assault, rape, kidnap, abduction, forced abortion, threats to kill and false imprisonment committed due to so called 'honour'. Murders in the name of 'so-called' honour, (often called Honour killings) are murders in which predominantly women are killed for actual or perceived immoral behavior which is deemed to have brought shame on the family. Some examples nationally of honour based murders have been for trivial reasons for example, dressing or behaving too westernised, falling in love with somebody not chosen by their family, rejecting forced marriage or being LGBTq.

8.4 Honour based violence represents a significant risk to the victim. Always adhere to the "One Chance Rule", you may only get ONE chance to speak with a potential victim and thus may only have ONE chance to save a life.

8.5 Respond IMMEDIATELY, any suspicion or disclosure of violence or abuse against a child or adult in the name of honour should be treated seriously.

8.6 Do not UNDERESTIMATE what the victim is saying or assume it's a cultural issue. Perpetrators of HBV really do kill, just the perception of a rumour or immoral behaviour may be sufficient to do so.

8.7 Relevant resources:

- https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/honour-based-violence
- https://www.haloproject.org.uk/definition-of-honour-based-violence-W21page-47

- https://karmanirvana.org.uk/about/honour-based-abuse

9. FORCED MARRIAGE

9.1 A forced marriage is where one or both people do not (or in cases of people with learning disabilities or reduced capacity, cannot) consent to the marriage as they are pressurised, or abuse is used, to force them to do so. It is recognised in the UK as a form of domestic or child abuse and a serious abuse of human rights.

9.2 The Forced Marriage Unit (FMU) is a joint Foreign and Commonwealth Office and Home Office unit which leads on the government's forced marriage policy, outreach and casework. It operates both inside the UK (where support is provided to any individual) and overseas (where consular assistance is provided to British nationals, including dual nationals).

9.3 A Forced Marriage Protection Order can help if individuals are either being forced into marriage or already in a forced marriage. Orders are unique to each case and contain legally binding conditions and directions that change the behaviour of a person or persons trying to force someone into marriage. The aim of the order is to protect the person who has been, or is being forced into marriage. The court can make an order in an emergency so that protection is in place straightaway.

9.4 The FMU operates a public helpline to provide advice and support to victims of forced marriage as well as to professionals dealing with cases. The assistance provided ranges from safety advice, through to helping a forced marriage victim prevent their unwanted spouse moving to the UK ('reluctant sponsor' cases). In extreme circumstances the FMU will assist with the rescue of victims held against their will overseas.

9.5 For advice and support contact the Forced Marriage Unit (FMU)

9.6 Forced Marriage Unit, fmu@fco.gov.uk, Telephone: 020 7008 0151

Monday to Friday, 9am to 5pm

Out of hours: 020 7008 1500 (ask for the Global Response Centre)

https://www.gov.uk/stop-forced-marriage

10. FEMALE GENITAL MUTILATION (FGM)

10.1 FGM comprises of all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons. FGM is most often carried out on young girls aged between infancy and 15 years old. It is often referred to as 'cutting', 'female circumcision', 'initiation', 'Sunna' and 'infibulation'[1].

[1] https://www.england.nhs.uk/wp-content/uploads/2016/12/fgm-pocket-guide-v5-final.pdf

10.2 From the 31st October 2015, regulated professionals in health and social care and teachers in England and Wales have a duty to report 'known' cases of FGM (Female Genital Mutilation) in under 18s to the police. Professionals who initially identify FGM must call 101 (police) to report.

10.3 If you are worried about a girl under 18 who is either at risk of FGM or who you suspect may have had FGM, you should share this information immediately with Children's Social Care or the Police. Where a child appears to be in immediate danger of mutilation, Children's Social Care and the police will urgently consider the need for a Female Genital Mutilation Protection Order, an Emergency Protection Order or a Prohibited Steps Order. Practitioners should make it clear to the family that they will be breaking the law if they arrange for the child to have the procedure.

10.4 Relevant resources:

- Violence Against Women & Girls (VAWG): https://www.forwarduk.org.uk/violence-against-women-and-girls/key-facts-about-vawg/
- FGM resource pack: https://www.gov.uk/government/publications/femals-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack#effective-practice-and-resources
- NHS England has produced a helpful pocket guide: https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

11. STALKING & HARASSMENT

11.1 Harassment and stalking can cause victims, their families and loved ones immense physical, psychological and emotional harm.

11.2 Well-publicised murders have involved stalking and other forms of persistent harassment. Offenders stalk or harass their victims online, by post or telephone, by direct personal contact or a combination of these channels, with a reported 75% of domestic violence stalkers turning up at the victim's workplace (MacKenzie, McEwan, Pathé, James, Ogloff, & Mullen, 2009).

11.3 A recent Crime Survey for England and Wales suggests there may be around 120,000 victims a year. Over the same period police recorded 52,500 offences involving harassment. Conviction rates are low, 4% or less depending on which of the two preceding figures are correct.

11.4 Statistics show that the majority of victims (80.4%) are female while the majority of perpetrators (70.5%) are male. (National Stalking Helpline, 2011).

11.5 Stalking and Harassment is a high risk factor in Domestic Homicides. The Metropolitan Police Service found that 40% of the victims of domestic homicides had also been stalked (ACPO Homicide Working Group, 2003).

11.6 As of the 25th November 2012 amendments to the Protection from Harassment Act have been made that makes stalking a specific offence in England and Wales for the first time.

11.7 The amendments were made under the Protection of Freedoms Act 2012. There are two new amendments; section 2A stalking, and section 4A stalking. To prove a section 2A it needs to be shown that a perpetrator pursued a course of conduct which amounts to harassment and that the particular harassment can be described as stalking behaviour. Stalking is not legally defined, but the amendments include a list of example behaviours which are; following, contacting/attempting to contact, publishing statements or material about the victim, monitoring the victim (including online), loitering in a public place, interfering with property, watching or spying. This is a non-exhaustive list which means that behaviour which is not described above may also be seen as stalking. A course of conduct is 2 or more incidents.

11.8 Section 4A is stalking involving fear of violence or serious alarm of distress. Again serious alarm and distress is not defined but can include behaviour which causes the victim to suffer emotional or psychological trauma or have to change the way they live their life. If at the trial of a 4A offence the jury find the offender not guilty, they may still be able to find the person guilty of an offence under 2A.

11.9 Sections 2 and 4 of the Protection from Harassment Act can also still be used to prosecute harassment. Harassment is described in the Act as a course of conduct which (a) amounts to harassment of another and (b) which they know ought to know amounts to harassment of another. Sections 2 and 2A are summary only offences and there is a maximum prison sentence of 6 months. Section 4 and 4A are either way offences with a maximum prison sentence of 5 years.

11.10 In addition, the 2012 Act clarifies references to harassment causing fear in the 1997 Act. It uses the phrase ‘substantial adverse effect on the usual day-to-day activities’. Examples might include victims fitting more security devices, changing routes to work or arranging for others to pick up children from school to avoid the attentions of a stalker. As a result the victim has less freedom.

11.11 Relevant resources:

•The National Stalking helpline: www.stalkinghelpline.org

•The Suzy Lamplugh Trust: www.suzylamplugh.org

•Victim Support line: www.victimsupport.org.uk

12. PREVALENCE AND IMPACT

12.1 Domestic Violence and Abuse is a significant public health issue, leading to increased risk of poor mental health, physical injuries, chronic physical conditions, unwanted and complicated pregnancy, sexually transmitted infections and substance misuse. The effects can often last a lifetime and into subsequent generations.

12.2 HM Government estimates the cost of domestic abuse to be approximately £66 billion in England and Wales for the year ending March 2017.

12.3 The cost to the NHS has been calculated at £1.73 billion. With mental health costs estimated at an additional £176 million.

12.4 The estimated cost of domestic abuse in Somerset is £61 million. The public services cost is £33.5 million, £15 million of which is attributed to healthcare.

12.5 Domestic abuse has significant psychological consequences, including anxiety, depression, PTSD, suicidal behaviour, flashbacks, sleep disturbances and emotional detachment.

12.6 1 in 8 of all suicides attempts by women in the UK is due to domestic abuse. This equates to just fewer than 200 women dying and nearly 10,000 attempting suicide each year.

12.7 Almost a quarter (24%) of Refuge clients (study based on 3500 women) had felt suicidal at one time or other. 18% had made plans to end their life, 3.1% had made at least one suicide attempt. (Source: Refuge and Warwick Law School)

12.8 Safelives report, A Cry for Health found that in the year before getting effective help, nearly a quarter (23%) of victims of domestic abuse at high risk of serious harm and murder, and one in ten victims at medium risk went to Accident and Emergency (A&E) because of their injuries.

12.9 Almost a third of domestic violence cases start during pregnancy with pregnant women more likely to have multiple sites of injury, and often reporting that abuse escalates throughout the pregnancy.

12.10 Pregnant women who are abused are more likely to experience serious pregnancy complications, such as miscarriage, high blood pressure and premature birth. They are also more likely to suffer emotional and mental health problems, such as depression.

12.11 Pregnant women who experience domestic violence and abuse are also more likely to have a baby who is stillborn. Blows to the tummy, pregnancy complications and irregular attendance at antenatal check-ups all increase the risk.

12.12 Between 2006 and 2008, domestic abuse was reported in 12 per cent of maternal deaths.

12.13 80% of older adults experiencing domestic violence and abuse are not visible to services. Of those visible to services, ¼ live with abuse for more than 20 years.

12.14 Victims aged 61+ are much more likely to experience abuse from an adult family member or current intimate partner than those 60 and under, and are much less likely to leave the perpetrator of their abuse. Often they experience an average of 12.9yrs of abuse before accessing support.

12.15 Older people have a lower level of complex needs in terms of mental health and substance misuse, but are more likely to have a disability/dependency issue.

12.16 Public Health England produced a report on domestic violence and abuse and disability in which they state the following: “Disabled women are significantly more likely to experience domestic abuse than disabled men and experience more frequent and more severe domestic abuse than disabled men. However, as being disabled carries further risk of domestic abuse, disabled men also experience higher rates of abuse than non-disabled men. Disabled men experience a similar rate of domestic abuse as non-disabled women.

12.17 Black and Minority Ethnic (BME) women can face additional barriers to accessing support, there are a plethora of reasons that a patient’s ethnicity, gender, disability, religion, sexuality or age may affect their experience of abuse, how and when they seek support and the type of support they need. This can include but not limited to: fear of the consequences of disclosure or not being believed, additional barriers to disclosure and service access in form of; language and communication difficulties, insecure immigration status or previous experiences of discrimination based on race, gender, religion, sex, marital status, pregnancy status, sexuality, disability and age.

12.18 Lesbian, gay, bisexual and transgender (LGBT) women / men can be vulnerable to abusers who undermine their sexuality and threaten to ‘out’ them to colleagues, employers and family members.

12.19 Transgender women and men may have fewer specialised services available to them.

12.20 Women and men experiencing domestic abuse and sexual violence may find it difficult to disclose the abuse. Rape and sexual abuse is an extremely difficult and traumatic experience for anyone who experiences it, with shame and stigma being felt by both sexes in disclosing. Specialist Sexual Violence Services, such as Somerset & Avon Rape and Sexual Abuse Support (SARSAS) have specialist helpline support for both men and women.

12.21 80% of women in a domestically violent or abusive relationship seek help from health services, usually general practice, at least once, and this may be their first or only contact with professionals.

12.22 There is extensive contact between women and primary care clinicians with 90% of all female patients consulting their GP over a five-year period. Safelives insights data for 2016/2017 shows over half (52%) of victims supported by a domestic abuse advocate had visited a GP in the past 12 months – on average, 4.5 times.

12.23 Relevant resources and reports:

- The Economic and Social Costs of Crime' (Heeks *et al.,* 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772180/horr107.pdf

- Public Health England produced a report of DVA and Disability https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf

- *Safelives report Cry for Health: http://www.safelives.org.uk/cry-for-health*

- Safelives report Older People and Domestic Abuse: http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

13. SAFEGUARDING

To comply with statutory safeguarding responsibilities it is vital to safeguard both adults and children at risk of domestic violence and abuse.

13.1 ADULTS AT RISK

13.2 The Care Act 2014 sets out a clear legal framework for how local authorities and partner organisations should protect adults at risk of abuse or neglect. Under The Care Act 2014 there are 10 definitions of abuse, one of which is domestic abuse.

13.3 The Care Act adult safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs), and;

- Is experiencing, or is at risk of, abuse or neglect, and;

- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

13.4 **To Report an Adult Safeguarding Concern**

- **Emergency**: If an adult is at imminent risk of harm and a crime has occurred ring **999** for an emergency response.
- If a crime has occurred but the situation is not an emergency the crime should be reported by calling **101**
- Non-emergencies and to seek safeguarding advice call Adult Social Care on **0300 123 2224**
- To submit a referral click the link online via the Somerset Safeguarding Adults Board website: www.ssab.safeguardingsomerset.org.uk
- Out of hours service: Call Adult Social Care on **01823 368244**

13.5 **CHILDREN AT RISK**

13.6 The Serious Crime Act 2015 makes it explicit that cruelty to children which causes psychological suffering is a crime. This includes when children are emotionally harmed by exposure to domestic abuse.

13.7 Where there is domestic violence and abuse, the wellbeing of the children in the household must be promoted and all assessments must consider the need to safeguard the children, including unborn child/ren. They are at increased risk of; physical, emotional, sexual abuse and neglect, in these environments.

13.8 Children's experiences of non-violent, control-based abuse in their homes must remain highly visible. Hearing the abusive parent call their mum or dad damaging names such as; "stupid" or "slut", being part of the oppressive regime where mistakes are not allowed and enforced social isolation limits access to supportive friends, family or social after-school clubs can result in a fear to learn new skills or even to speak freely.

13.9 Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. Each child will respond differently to trauma and some may be resilient and not exhibit any negative effects.

13.10 Children's responses to the trauma of witnessing domestic abuse may vary according to a multitude of factors including, but not limited to, age, race, gender and stage of development. It is equally important to remember that these responses may also be caused by something other than witnessing domestic abuse.

13.11 When the abuser is demanding constant attention, children miss out on quality time with their non-abusive parent and the self-esteem that this can build. Despite the isolation that children live with, there is also extensive evidence that children will actively resist the perpetrators regimes of coercive control.

13.12 Children are individuals and may respond to witnessing abuse in different ways. These are some of the effects described in a briefing by the Royal College of Psychiatrists (2004):

- They may become anxious or depressed
- They may have difficulty sleeping
- They have nightmares or flashbacks
- They can be easily startled
- They may complain of physical symptoms such as tummy aches and may start to wet their bed
- They may have temper tantrums and problems with school
- They may behave as though they are much younger than they are
- They may become aggressive or they may internalise their distress and withdraw from other people
- They may have a lowered sense of self-worth
- Older children may begin to play truant, start to use alcohol or drugs, begin to self-harm by taking overdoses or cutting themselves or have an eating disorder
- Children may also feel angry, guilty, insecure, alone, frightened, powerless or confused. They may have ambivalent feelings towards both the abuser and the non-abusing parent.

13.13 Relevant resources:

- https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/impact-on-children-and-young-people/
- https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-effects-on-children
- Safelives 2014-17 Report: http://safelives.org.uk/sites/default/files/resources/Children%27s%20Insights%20dataset%202014-17%20v2.pdf
- https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/impact-on-children-and-young-people/
- https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/domestic-abuse

13.14 Where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm, professionals should act in accordance with their organisations child safeguarding policy.

13.15 South West Child Protection Procedures:
http://www.proceduresonline.com/swcpp/somerset/

- If you are worried about a child or young person who could be in danger **(child protection Level 4 threshold)** please contact Children's Social Care on: **0300 123 2224** or the police.

- You can contact the police directly by dialling 101 and they will discuss with Children's Social Care what action should be taken. In an emergency always contact the police by dialling **999**.

- If you would like to speak to a social worker outside office hours please phone the Emergency Duty Team (EDT) on **0300 123 23 27**

14. SOMERSET MULTI-AGENCY RISK ASSESSMENT CONFERENCES (MARAC)

14.1 The identification of high risk domestic abuse is everyone's business. The completion of a domestic abuse risk assessment (ACPO-DASH) helps assess the severity of the presenting risk. (Please refer to Appendix: Standard Operating Procedures for assessment of risk and the completion of the ACPO-DASH). This starts the process towards a MARAC where the aim is to ensure effective support to the right people without delay.

14.2 **What is a MARAC?**

14.3 MARAC is a partnership approach with a core objective to share information about domestic abuse victims, perpetrators and families. This involves a number of agencies including Children's Social Care, Adult Social Care, Police, Housing, Education, Specialist Domestic Abuse Services and Mental Health.

14.4 There are four MARAC meetings regularly held in Somerset, these are Sedgemoor, Taunton/West Somerset, South Somerset and Mendip.

14.5 Each agency signed up to MARAC has a MARAC representative who attends meetings and is responsible for the actions of their agency.

14.6 MARAC runs alongside other multi-agency assessment processes and so must link appropriately to avoid duplication (i.e. MASH, Channel).

15. SOMERSET MARAC OPERATING PROTOCOL

The MARAC is designed to enhance existing agency arrangements rather than replace them, the Somerset protocol identifies how the MARAC will link with other processes to safeguard children and adults and manage the behaviour of the perpetrator.

15.1 As a key partner health services must appoint at least one MARAC Representative who should be a manager or person of sufficient standing within their agency to prioritise actions, commit resources and share appropriate information.

15.2 The agency representative will be expected to attend the MARAC if a meeting is required and be responsible for communicating the information therein to relevant colleagues. The representative will ensure that MARAC referrals from their agency are appropriate.

15.3 Each agency's representative must have an identified deputy to ensure consistent representation in the MARAC. They must either be an operational manager or if a frontline professional have delegated authority to take all appropriate actions to ensure their agency is fully able to contribute to each victim's multi agency safety plan.

15.4 When an agency representative changes, the following should occur:

- The outgoing MARAC representative should inform Somerset Integrated Domestic Abuse Service as soon as possible and identify who the new representative will be (including provision of secure contact details).
- The outgoing representative should give a handover to the new representative in particular identifying any outstanding or ongoing actions for that agency.
- Somerset Integrated Domestic Abuse Service will contact the new MARAC representative and provide an overview of the process and answer any questions.
- The new representative must attend local Level 1 Domestic Abuse Training (as available via www.somersetsurvivors.org.uk) ideally before attending MARAC, or as soon as possible in order to ensure they have an up to date and good understanding of domestic abuse.
- Other agencies not signed up to the Somerset MARAC Information Sharing Protocol may be involved in the MARAC process on a case by case basis and will be required to sign a confidentiality declaration.

16. SHARING INFORMATION IN CASES OF SUSPECTED DOMESTIC ABUSE

16.1 Health Practitioners who encounter domestic abuse victims, perpetrators and their families often need to assess how to share personal information about clients with other professionals. Lawful and responsible information sharing can be vital to help victims and their children (or other dependents) safe, to carry out risk assessment, to provide support and advocacy services and help bring perpetrators to justice.

16.2 **Legal Framework and Guidance for Information Sharing**

16.3 **The Data Protection Act 2018** defines consent as: a 'freely given specific and informed indication of his or her wishes by which the data subject

signifies his or her agreement to personal data relating to him or her being processed'.

16.4 **When obtaining consent to disclose personal information it should be made clear:**

- Why the information is to be shared (the reasons, purpose and intended outcome);
- Which agencies or named practitioners the information will be shared with;
- What information is to be shared.

16.5 For the purpose of this guidance, it is assumed that no consent has been obtained from any individual (the victim, the victim's children and/or the alleged/suspected perpetrator) as to the sharing of their information.

16.6 In practice, consent should always be sought if possible and it is safe to do so, although the individual practitioner needs to take an independent decision on whether sharing information is necessary and permitted by law to address the safety of the individual or individuals.

16.7 If consent is not obtained, disclosures can still be made under the Data Protection Act (DPA), the Human Rights Act (HRA) and the Caldicott Guidelines. Decisions to disclose must;

- Be reached on a case by case basis
- Be based on a necessity to disclose
- Ensure that only proportionate information is disclosed in light of the level of risk or harm to a named individual or a known household in each case.
- Be properly documented at the time a disclosure decision are being made (i.e. what risk is believed to exist), what information will be disclosed and what restrictions on the use of the disclosed information will be placed on its recipients

16.8 **Laws and guidance governing domestic abuse disclosures (including at Multi Agency Risk Assessment Conference (MARAC).**

- Data Protection Act 2018 (the DPA)
- Human Rights Act 1998 (the HRA)
- Common Law duty of confidence
- The Crime and Disorder Act 1998
- Caldicott Guidelines: as these are guidelines only, if conflict exists between them and the DPA and HRA, the legislation must take precedence.

16.9 **Data Protection Act** – the prevention of crime exemption under Section 29 of the DPA can be used if disclosure is necessary to prevent a crime against a named individual or specified household. The risk of crime must be a genuine or likely risk.

16.10 **Common Law duty of confidence** – An obligation of confidence will exist where the individual has provided the information to another in circumstances where it is reasonable to assume that the provider of the information expected it to be kept confidential. Where there is a clear duty of confidence the information can only be disclosed to "third parties" if there is informed consent, compulsion of law or public interest.

16.11 **Human Rights Act** – A disclosure will comply with HRA if it:

- Is made for the purpose of preventing crime, protecting the health and/or safety of alleged victims and/or the rights and freedoms of those who are victims of domestic violence and/or their children; and
- Is necessary for the purposes referred to in (a) above and is no more extensive in scope than is necessary for those purposes; and
- Complies with all relevant provisions of law, including the DPA and the Caldicott Guidelines.

16.12 **The Crime and Disorder Act 1998** – Any person may disclose information to a relevant authority under Section 115 of the Crime and Disorder Act 1998, 'where disclosure is necessary or expedient for the purposes of the Act (reduction and prevention of crime and disorder)'. 'Relevant authorities', broadly, are the police, local authorities, health authorities (clinical commissioning groups) and National Probation Service and Bristol/Gloucestershire/Wiltshire and Somerset (BGSW) Community Rehabilitation Company.

16.13 **Caldicott Guideline** – Where an individual has not consented to the use of their information, that individual's wishes should be respected unless there are exceptional circumstances. One such exceptional circumstance arises where there is a serious public health risk or risk of harm to the patient or other individuals, or for the prevention, detection or prosecution of serious crime.

16.14 **The Seven Caldicott Principles are**:

- Justify the purpose(s) of using confidential information
- Only use personal confidential data unless absolutely necessary
- Use the minimum necessary personal confidential data that is required
- Access should be on a strict need-to-know basis
- Everyone must understand his or her responsibilities
- Understand and comply with the law
- The duty to share information can be as important as the duty to protect patient confidentiality

16.15 Cases considered at MARAC meetings are likely to constitute exceptional circumstances as defined by the Caldicott Guidelines. MARAC's are a forum to discuss the most serious cases of alleged or suspected domestic abuse. However, each case must be considered individually, taking into account specific circumstances.

16.16 Practitioners should be aware that Caldicott Guidelines are not law and that the DPA, HRA and common law will always take precedence. If there is apparent conflict between legislation and common law, legislation takes precedence.

16.17 **Seven Golden Rules for Information Sharing**

- Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

- Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

- Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the person where possible.

- Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

- Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

- Necessary, proportionate, relevant, accurate, timely and secure: Ensuring that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

- Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared with whom and for what purpose.

17. TRAINING & DEVELOPMENT

17.1 The NICE Quality Standard, 2016 recommends that all health practitioners involved in assessing, caring for and supporting people experiencing or perpetrating domestic violence and abuse should have

sufficient and appropriate training and competencies to deliver the actions and interventions described in this policy.

17.2 The quality standard means that:

- **Commissioners**: ensure that they commission services in which frontline staff are trained to deliver safe and effective actions and interventions appropriate to their role, including documentation of discussions. Those services should raise awareness and address misconceptions about domestic violence and abuse, whilst ensuring that frontline staff have the skills and training to provide effective support.

- **Service Providers**: ensure that frontline staff are trained to deliver safe and effective actions and interventions appropriate to their role. The Somerset standard for enhancing the response to domestic abuse across health settings has been directed by a consortium of experts and agreed with the Safer Somerset Partnership stakeholders. It is therefore recommended that providers adopt the agreed standard.

- Training should be provided by qualified trainers, and use accredited materials.

- **Health Practitioners**: trained to deliver safe and effective actions and interventions. Should ask about domestic violence in a way that facilitates disclosures, in a private discussion, in a sensitive manner and in an environment in which the person feels safe. They should respond sensitively and in a way that ensures the person's safety; they should offer referral to specialist support and document discussions, agreed actions and outcomes.

17.3 Training should be delivered in accordance with national and local training standards and assessment framework.

17.4 The Somerset Level 2 & 3 Domestic Violence & Abuse Training is designed to deliver the competencies outlined in the NICE Quality Standard 2016 and is the agreed Safer Somerset Partnership standard for Somerset. Staff should refer to Trust Safeguarding Leads for advice regarding attendance.

18. MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY

18.1 The core domestic abuse policy for Somerset will be reviewed every 3yrs or sooner through a system wide consultation and in accordance with regional and national standards.

18.2 Somerset CCG will provide regular reports to the Safeguarding Assurance Group of the activities and developments concerning the implementation and compliance with the core principles outlined in the policy.

Guidance for Standard Operating Procedure

DOMESTIC ABUSE

19. PROCEDURE

19.1 IDENTIFYING PATIENTS AT RISK

19.1 The Department of Health has recognised Domestic Violence and Abuse as a serious Public Health issue.

19.2 Health Service staff have a valuable contribution to make in the identification and response to patients exposed to domestic abuse. The NHS is the one service that almost all victims of abuse will come into contact with.

19.3 ***NICE Quality Statement 1:*** Evidence of local arrangements to ensure that people presenting to frontline staff with indicators of domestic abuse are asked about their experience in a private discussion.

Services should ensure that they can provide a safe and private environment in which people feel able to disclose that they are experiencing domestic violence and abuse. In some healthcare settings (for example, emergency departments, maternity services, mental health, sexual health and drug or alcohol services), it is recommended that routine or selective clinical enquiry be adopted.

19.4 **Patients Presenting with Indicators of Domestic Violence and Abuse**

SafeLives' Insights dataset found that on average, a victim will experience abuse for three years before getting effective help and will visit their GP on average 4.3 times. Therefore it is imperative that health professionals are equipped to ask the right questions and support victims through disclosure and referral.

In response to prolonged abuse, people may have complex needs and multiple disadvantages. The term multiple disadvantage refers to those people who face multiple and intersecting inequalities including gender-based violence and abuse, substance use, mental ill health, homelessness, being involved in the criminal justice system and children having been taken in local authority foster care.

19.5 Source: https://avaproject.org.uk/wp/wp-content/uploads/2013/05/AVA-Toolkit-2018reprint.pdf

19.6 **Example Indicators of Domestic Violence and Abuse**

There are significant and strong associations between domestic violence and many illnesses, notably psychiatric complaints, such as depression and self-harm, and drug and alcohol misuse. Other strong associations exist with termination of pregnancy, sexually transmitted diseases and medically unexplained symptoms. (NICE Quality Standard, 2016)

- Symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders
- Suicidal tendencies or self-harming
- “Stranger” assault, “Falls”
- Alcohol or other substance misuse
- Unexplained chronic gastrointestinal symptoms
- Unexplained gynaecological symptoms, including pelvic pain and sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies or terminations
- Delayed pregnancy care, miscarriage, premature labour and stillbirth
- Genitourinary symptoms, including frequent bladder or kidney infections
- Vaginal bleeding or sexually transmitted infections
- Chronic unexplained pain
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- High risk injury: mid-arm injuries (defensive), strangulation marks, weapon injuries or marks, injuries to areas not prone to injury by falls, old as well as new injuries, bites and burns (scalding and cigarettes), injuries to multiple sites, symmetrical injuries, poor nutrition.
- Common injury: mid face injury, black eyes, dental injuries, breast/abdominal injuries, injuries hidden by clothing, internal injuries.
- Problems with central nervous system – headaches, cognitive problems, hearing loss

- Repeated health consultations with no clear diagnosis
- Intrusive ‘other person’ in consultations, including partner or spouse, parent, grandparent or an adult child (for elder abuse)
- Injuries inconsistent with explanation of cause, patient tries to hide injuries or minimise their extent.
- Genitourinary symptoms, including frequent bladder or kidney infections
- Frequent missed appointments, early self-discharge

(Recurrent UTIs: Research has found that women who experienced intimate partner violence had three times the risk of gynaecological problems compared to non-abused women (McCauley J et al. The “battering syndrome”: prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. Annals of Internal Medicine, 1995, 123(10):737–46.)

It should of course be recognised that a patient displaying one or more of the above symptoms may not be a victim of domestic abuse.

20. THE ROLE OF THE HEALTHCARE PROFESSIONAL

20.1 Health Professionals may be the first people that patients confide in about their experience. These individuals are most at risk of increased life threatening abuse when they start to disclose abuse or try to leave an abusive relationship.

20.2 Any conversation and questions should be phrased sensitively and responded to with empathy and understanding.

20.3 Response to disclosure should be; non-judgemental, non-victim blaming and include an acknowledgement of the cause when talking about symptoms.

20.4 **The Health Professional should**

20.5 Be aware that the patient’s family member or intimate partner may not allow them to have a consultation alone. Abusers may also attempt to control the situation by dominating consultations and making decisions for the patient.

20.6 Make every effort to speak with the person in private, ensuring that any visitors are asked to leave. A person may have multiple abusers and friends or family members may be colluding in the abuse.

20.7 It is recommended the professional facilitate disclosure in private without any third parties present. If a patient discloses abuse in front of a friend or family member, the professional should use their professional authority

and ask the accompanying person to leave the room, or take the patient for a treatment alone (e.g. urine sample, blood test, x-ray).

20.8 If a patient requires an interpreter, call a language interpretation service. Do not use the patient's family or friends to interpret regarding abuse or the internet such as google translate. Be aware when using an interpreter that the definition of abuse may change according to the language. Be aware of gender when requesting an interpreter, female patients may prefer a female interpreter.

20.9 If the patient is accompanied by an adult or a child above the age of 18months, it is recommended that staff create an opportunity to speak with the patient alone.

20.10 DO NOT ask a patient about domestic violence and abuse if:

- The patient is accompanied by another adult
- The patient is accompanied by children above the age of 18months,
- Always consider the risk if a child can communicate verbally and inadvertently reveal to the abuser what was discussed.

Studies indicate that without specialist support violence and abuse can escalate in frequency and severity, having long term implications on health and wellbeing.

21. UNDERSTANDING THE BARRIERS TO DISCLOSURE

21.1 Evidence suggests that patients who are being subjected to violence and abuse want to be asked, and that patients who are not, do not mind being asked (Friedman et al; 1992).

21.2 Patient's experiencing abuse are often afraid to talk about what is happening to them, and in many cases either not identifying that their experience is classified as domestic abuse, or unaware of the services and support available.

21.3 They may feel unsure of how to start the conversation, fearful of being judged, ashamed, embarrassed, or not feel worthy of help and support. They are also likely to feel that they are betraying their partner; afraid of what will happen next, worried about how they will cope, and what they may have to do to leave the relationship.

21.4 Patients may face additional barriers to disclosure and access to services due too: language and communication difficulties, insecure immigration status or previous experiences of discrimination based on race, gender, religion, sex, marital status, pregnancy status, sexuality, disability and age. Intersectionality; namely how aspects of one's social identities might combine to create unique modes of discrimination and thus prevent further barriers to disclosure must also be considered.

21.5 They may have previously encountered a negative experience of disclosure. It is important to remember that the health professional's response is key to the survivor accessing help and support.

21.6 Domestic abuse is a complex psychological dynamic rooted in values and beliefs that can result in the victim being rendered "immobilised", afraid to stay and afraid to leave.

22. FRAMEWORK FOR CLINICAL ENQUIRY: AVAA MODEL

- **1. ASK (Disclosure)**
- **2. Validate**
- **3. Assess**
- **4. Action**

22.2 In recognition; that many domestic abuse survivors may not realise that their experience is classified as domestic abuse, or simply may not yet be ready to engage in support. It is recommended, in some healthcare settings (for example, emergency departments, maternity services, sexual health services and mental health and drug or alcohol services) that observational/selective enquiry or routine enquiry be adopted.

22.3 **AVAA: Ask**

- Step 1: Check, Is it Safe?
- Step 2: Ask a generic introductory question
- Step 3: Explain why you are asking
- Step 4: Ask a more direct question

22.4 **How to Ask about Domestic Violence and Abuse**

- To establish a relationship with the patient, develop empathy and provide an opportunity for further questioning. Health Professionals may use a generic line of enquiry to open up the conversation before advancing to a more directed question, for example:
- How are things at home?
- Are you getting the support that you need at home?
- Do you have concerns about your partner/family?

22.5 Direct questioning has been found to lead to disclosure of domestic violence and abuse. Proactive enquiry informs the patient that professionals are listening, available and confident in their response to violence and abuse at home.

22.6 Many victims explain their previous non-disclosure due to the fact that they were never directly asked.

22.7 Framing and directing is the recommended style of questioning - domestic violence being the contextual framework, followed by a direct question more specifically about the patient's experience. Examples detailed below may be utilised in both routine and observational/selective enquiry.

Supporting resource: http://www.safelives.org.uk/cry-for-health

Framing & Directing the Question:

- "Given the widespread nature of violence and abuse, we routinely screen for risks at home", "Is there anyone at home that has threatened to hurt you or someone that you care about?"
- "Violence and abuse at home is common", is there anyone that makes you feel unsafe or that you are frightened of?"
- "Women exposed to abuse at home are particularly vulnerable to pre and post-natal stress", "Is there anyone at home that makes you feel unsafe? Anyone who's behaviour concerns you"?
- "Not everyone recognises that they are in an abusive relationship", Does anyone consistency put you down or belittle you? Threaten or intimidate you?
- "I am concerned about your symptoms, is there someone at home hurting you?"
- "How are you coping at home"? Is there anything that you are worried about? Is there anyone that makes you feel unsafe?
- What happens when you and your partner / ex-partner / family member argue? What sort of things do you argue about?
- Who makes the rules in your household? What happens if you don't obey?
- Do you ever change your behaviour because you are worried about how someone at home might react?

22.8 **Explain the parameters of confidentiality**

22.9 It is essential to ensure transparency around information sharing parameters. Advise patients of your duty to safeguard individuals and the parameters of confidentiality. For example; 'Everything you tell me is confidential; I do not routinely share information without your consent.

However, if I do feel that there is a risk of harm to yourself or someone else, I may have to share that information with other professionals'.

22.10 Remember that a survivor may be fearful about the implications of information sharing. For example they may have had previous negative experiences with services, or the perpetrator may be using the threat of the involvement of services to control them.

22.11 Staff must emphasise that actions offered, and information sharing is a supportive measure to reduce harm. They must offer support around the outcome of information sharing.

23. RESPONSE & ASSESSMENT

23.1 **NICE Quality Statement 2**: Evidence of local arrangements to ensure that staff are trained to provide a universal level 1 or 2 response to domestic violence and abuse.

23.2 *People experiencing domestic violence and abuse should expect staff to respond consistently and appropriately. Training staff to respond to disclosure (level 1) and how to ask about domestic violence and abuse (level 2) is essential for safe enquiry about experiences of domestic violence and abuse and a consistent and appropriate response.*

23.3 **AVAA: Validation**

- Listen
- I believe you
- You have the right to live free from violence and abuse
- Abuse is not your fault
- You are not alone
- We can help you to access support

23.4 Reassure the person that their disclosure is confidential and will not be shared with the abuser, that the abuse is not their fault and that they can access help and support. This may be the first time the patient is talking about their experience of domestic violence and abuse, how health professionals respond is key to the survivor accessing appropriate services and support.

23.5 **AVAA: ASSESSMENT**

23.6 Determine if there is an immediate risk to the victim/child? Who they are at risk from, if there is a risk of multiple perpetrators and who else may potentially be at risk? (Consider risk to children, unborn baby and vulnerable adult). Check.

A. Is the perpetrator with them?

B. Where are the children?

C. Is it safe for them to return home today?

D. Do they have immediate concerns

E. Do they have a place of safety?

Consider the actuarial risk, the indicators highlighted in the disclosure that may denote the probability of serious harm or homicide, consider the SPECSSS model (refer to 23.9).

If there is a risk of immediate harm the healthcare professionals should speak with their clinical or safeguarding lead prior to initiating immediate safety action in accordance with Trust policy and departmental procedure. Safety plans should be secured before assessing for ongoing risk, for example requesting security, the police or a duty social worker.

Further questions which may prompt disclosure and inform healthcare professionals about the severity and frequency of abuse may be utilised.

- When was the last escalated incident, what happened?
- Is this the first injury that the patient has sustained? How does it compare to previous injuries?
- Does the abuser intimidate or threaten the patient?
- Would the patient describe their abuser as controlling or psychologically abusive?
- Is the abusers behaviours getting worse, are the incidents of conflict happening more frequently?
- Identify the location of the alleged abuser, and if the patient is frightened of them?
- What is it that the patient is frightened of?

23.7 **In the event of Non-Disclosure**

23.8 If indicators of domestic abuse have been identified, and opportunities to create a safe environment have been exhausted but not achieved staff must safely document their concerns and make plans to ensure that domestic abuse enquiry is safely followed up as a matter of urgency. For example:

- Sharing concerns internally with staff supporting the patient if they remain in the Trust and creating a plan for how enquiry may be facilitated.

- Making a follow up appointment with the patient as a matter of urgency and consider arranging this appointment at a time/location where a safeguarding practitioner or domestic violence specialist will be available.

23.9 **AWARENESS of Key Risk Factors: SPECSSS**

23.10 SPECSSS references six high risk indicators that have been identified from Domestic Homicide Reviews.

- Separation
- Pregnancy
- Escalation
- Community / Additional Factors
- Stalking
- Sexual Abuse
- Strangulation / Threats to Kill

23.11 SPECSSS is designed to strengthen professional judgement and understanding of the risks associated with domestic violence and abuse, whilst also acting as an alert to prompt referrals to the Trust Safeguarding Service. If any one of the indicators are present within the initial assessment/disclosure immediate action must be considered.

24. ACPO DOMESTIC ABUSE STALKING & HARRASSMENT RISK ASSESSMENT

24.1 If domestic abuse is identified a Domestic Abuse Stalking and Harassment Risk Identification Checklist (ACPO DASH) should be completed.

24.2 It is recommended that only staff who have undertaken specific ACPO DASH training complete the assessment with the patient. Refer to Trust Safeguarding procedures and identify designated professionals such as: Department Domestic Abuse Link (DAL), Domestic Abuse Coordinator (DAC), Independent Domestic Violence Advocate (IDVA) or Advocate Educator (AE).

24.3 The ACPO DASH risk assessment helps frontline practitioners identify high risk cases of domestic abuse, stalking and ‘honour’-based violence. The tool is designed to:

- Inform professionals of which cases should be referred to MARAC and what other support might be required.

- To offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.

- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

24.4 In the event of the ACPO DASH not being completed, professional judgement must inform all risk assessments, SPECSSS, with the patient's own perception of risk remaining central to the assessment.

25. ACTIVATING A RESPONSE TO SAFEGUARD PATIENTS AT RISK OF DOMESTIC ABUSE

25.1 N**ICE QUALITY STATEMENT 3**: Evidence of local referral pathways to ensure that people experiencing domestic abuse are referred to specialist support.

25.2 *It is important that people who disclose that they are experiencing domestic violence or abuse can access appropriate support. This should include support for any children in their family who are affected. Specialist support services can help to address the emotional, psychological, physical and sexual harms arising from domestic violence and abuse.*

25.3 All incidences of domestic violence and abuse should be reported to the Trusts safeguarding service. It is recommended that safeguarding services offer specialist advice and support to patients at risk of domestic violence and abuse via designated professionals such as an Independent Domestic Violence Advocate (IDVA) or Advocate Educator (AE) or as a minimum, quality assure the health professionals activation of a specialist community response.

25.4 **INDEPENDENT DOMESTIC VIOLENCE ADVISOR (IDVA)**

25.5 An IDVA is **an accredited Domestic Violence Advisor whose** main purpose is to address the safety and wellbeing of victims at high risk of harm from intimate partners, ex-partners or family members.

25.6 It is recommended that Trusts have access to Domestic Violence Advocates who can deliver specialist intervention within the care pathway.

25.7 Somerset Integrated Domestic Abuse Service is Somerset's main specialist service to provide support to men, women and children who are affected by domestic abuse. They offer a variety of services including support to adult victims/survivors in the community, emergency accommodation (e.g. refuge or safe-house), children affected by domestic

abuse, and support to those who cause harm and want to change their behaviour.

25.8 If you would like more information, please telephone the Somerset Domestic Abuse Helpline on 0800 69 49 999.

Opening Hours - 8am to 8pm Monday to Friday and 9am to 1pm Saturday/Sunday

25.9 To make a victim referral to the Somerset Integrated Domestic Abuse Service http://www.somersetsurvivors.org.uk/how-to-make-a-referral/

25.10 **Recommended referral criteria to a MULTI AGENCY RISK ASSESSMENT CONFERENCE (MARAC)**

25.11 **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. ***This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.*** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet the threshold criteria.

25.12 **'Visible High Risk':** the number of 'ticks' on the checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.

25.13 **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but **this will need to be reviewed** depending on local volume and level of police reporting.

25.14 If the completed ACPO-DASH risk assessment indicates that a child / adult / family is at **'Visible High Risk' - 14 or more 'yes' boxes** or the case meets the criteria on the grounds of professional judgement or escalation then a referral to Somerset Multi Agency Risk Assessment Conference (MARAC) http://www.somersetsurvivors.org.uk/how-to-make-a-referral/ should be actioned.

25.15 **AVAA: ASSESSMENT – Further Guidance**

25.16 People are at greater risk of domestic homicide at the point of separation or after leaving a violent partner. Be aware that the patient is more likely to feel in a heightened state of risk post disclosure, breaching the

established power and control mechanisms will likely aggravate their abuser and conflict may escalate.

25.17 The person is likely to feel exposed and concerned about what is going to happen. Be clear about what support can be offered and what actions you have agreed.

25.18 Only 1 in 5 survivors of abuse are ready to report their concerns to the police, encourage engagement with domestic abuse professionals (e.g. Independent Domestic Violence Advisors) who work independently from the police and can offer specialist advice and support.

25.19 Do not suggest that the patient leave the relationship. Staff should not offer their personal views or make comments that could be perceived as judgemental. Domestic abuse is complex in nature. There are many barriers to disclosure and many reasons why a person experiencing abuse may feel isolated and powerless to leave.

25.20 The patient's rights should be respected. The patient may not yet be ready to engage with support but will feel reassured by your support which may indeed prompt them to engage at a later date. If you feel there may be a risk of serious harm or threat to life you should contact your line manager to explore the risk and agree appropriate actions. Disclosures and concerns should be recorded and documented in a factual/neutral manner.

25.21 Do not override the patient's decision of not contacting the police unless there is a threat to their life or to their children. Calling the police against the patients wish can increase the risk and severity of the abuse. In most instances the patient is the best gauge of their risk.

25.22 **Where a patient is assessed to be at High Risk**

25.23 Gain consent to share information and process appropriate referrals. You may still share information without consent, if in your professional judgement, that lack of consent can be overridden in the public interest.

25.24 Where a patient is assessed to be at high-risk of serious harm or homicide or there is a risk to a child, unborn or vulnerable adult, action will need to be taken regardless of whether the survivor consents. However when safe to do so, the patient must always be made aware of the action being taken.

25.25 There may be instances where informing the survivor of action being taken may increase their risk of harm, including, but not exclusively, a risk that the perpetrator will be made aware of action being taken. If this is the case, the patient must not be informed until safe to do so

25.26 **MULTI-AGENCY RISK ASSESSMENT CONFERENCES (MARAC) IN SOMERSET**

25.27 The identification of high risk domestic abuse is everyone's business. The completion of a domestic abuse risk assessment (ACPO-DASH) helps assess the severity of the presenting risk. This starts the process towards a MARAC where the aim is to ensure effective support to the right people without delay.

25.28 **What is a MARAC?**

25.29 MARAC is a partnership approach with a core objective to share information about domestic abuse victims, perpetrators and families. This involves a number of agencies including Children's Social Care, Adult Social Care, Police, Housing, Education, Specialist Domestic Abuse Services and Mental Health.

25.30 There are four MARAC meetings regularly held in Somerset, these are Sedgemoor, Taunton/West Somerset, South Somerset and Mendip.

25.31 Each agency signed up to MARAC has a MARAC representative who attends meetings and is responsible for the actions of their agency.

25.32 MARAC runs alongside other multi-agency assessment processes and so must link appropriately to avoid duplication (i.e. MASH, Channel).

25.33 **How to make a Referral to MARAC**

25.34 MARAC cases can be referred from any agency. The perpetrator(s) should never be told of the MARAC process.

25.35 An ACPO DASH Risk Identification Checklist [commonly known as a DASH or RIC] must be completed by staffs who have undertaken specific ACPO DASH training.

25.36 The ACPO DASH must be sent with a Somerset Integrated Domestic Abuse Service (SIDAS) intake form to the Somerset Domestic Abuse Service, for further guidance refer to the 'how to make a referral' page on http://www.somersetsurvivors.org.uk/how-to-make-a-referral/

25.37 Once the referral and DASH is received the Somerset Domestic Abuse Service will assess risk and if appropriate a dedicated Independent Domestic Violence Advisor (IDVA) will establish contact with the person and represent them at a MARAC.

25.38 The MARAC takes place and information is shared by agencies, who should ensure they are clear on the actions they can and will take, and by when to ensure the safety of the adult and their children/other dependents.

25.39 **Does the victim have to consent to share their information?**

25.40 It is always advised to gain consent from the person as safety planning will be more effective if s/he agrees to work with the Independent Domestic Violence Advisor (IDVA). However, when considering the

safety of patients who are at high risk of harm, gaining consent is not always necessary. Professionals are advised to seek guidance from their clinical lead.

25.41 **What If The Case Does Not Reach The Criteria For MARAC?**

25.42 If a patient does not meet the criteria for MARAC they can still be referred to a specialist Domestic Violence Advocate within the trusts safeguarding team or to Somerset Integrated Domestic Abuse Service.

25.43 **What Happens After The MARAC?**

25.44 The IDVA will inform the victim about the agreed safety measures and support offered by the MARAC partners.

25.45 **What Happens If The Abuse Continues?**

25.46 If a victim whose case has already been considered at a MARAC later reports an incident to any agency, that agency must refer the case back to the MARAC as a repeat case. This allows the MARAC to re-design the safety plan, taking the new information into account.

25.47 Domestic violence and abuse is a complex issue that needs sensitive handling by a range health and social care professionals.

26. **NICE QUALITY STATEMENT 4:** evidence of local referral pathways to ensure that people who disclose that they are perpetrating domestic abuse are referred to specialist support services.

26.1 *People who disclose that they are perpetrating domestic violence and abuse should be able to access evidence-based specialist services. Health and social care practitioners should identify available local services and know how to access these. Providing support for perpetrators can reduce the incidence of domestic violence and abuse*.

27. PERPETRATORS WHO ARE PATIENTS

27.1 The primary aim of identifying a responding to patients who disclose that they are perpetrating abuse is to ensure the safety and wellbeing of the victim/survivor and their children.

27.2 Some perpetrators may identify their abusive behaviour directly and ask for help to deal with their violence. This is likely to have been prompted by a crisis such as a particularly bad assault, an arrest or ultimatum from the survivor. Such patients – even though they have come voluntarily – are unlikely to admit responsibility for the seriousness or extent of the abuse, and may try to “explain” the abuse or blame other people or factors. Even those who are concerned enough about the abuse to approach an agency may present with other related problems such as alcohol, stress or depression, and may not refer directly to the abuse.

27.3 Engaging with perpetrators about their abusive behaviour in order to refer them to specialist services should not take place as part of any form of 'couples' or 'joint family' work. The model is about aiding the perpetrator to address abusive behaviours and should be carried out independently from the victim/survivor.

27.4 **PERPETRATORS AS PARTNERS OF PATIENTS**

27.5 People who insist on accompanying their partners to appointments or who want to talk for their partners may appear to be caring and protective of their partners and very plausible. Direct engagement with an abusive person who is not the health professionals' patient may be difficult. However, being aware of the indicators of domestic abuse is important for any dealings with the perpetrator.

27.6 **ABUSING MEN AS FATHERS OF CHILDREN WHO ARE PATIENTS**

27.7 There are clear links between domestic abuse and child abuse. Health professionals may know children affected by domestic abuse and may come across the perpetrator/abusive father. (Refer to section 7.8 Children at Risk for clear guidance around safeguarding and child protection procedures).

- I've got a problem with drink
- I need anger management
- I'm not handling stress at work
- My partner says I need to see you
- My partner and I are fighting a lot
- My partner and I need counselling
- My partner is not coping and taking it out on me
- The kids are out of control and she's not firm enough
- I'm depressed/anxious/stressed/not sleeping/not coping/not myself
- I feel suicidal (or have threatened or attempted suicide)
- I'm worried about my rage at work, in the car, in the street, at the football.

27.8 **Additional behaviours/indicators to be aware of:**

- Attempts to accompany or speak for partners

- Sexual jealousy or possessiveness
- Recent mental ill-health relating to violence
- Substance use/dependence
- Excessive telephoning or texting
- Checking on the person's whereabouts

27.9 Although rare, an abuser might present with a physical injury such as a hand injury caused by punching, or you might notice injuries caused by the victim defending themselves such as scratch marks.

27.10 **Guidance on how to speak to suspected perpetrators**

27.11 A heath professional's response to any disclosure, however indirect, could be significant for encouraging responsibility and motivating a perpetrator towards change.

27.12 If a perpetrator presents with a problem such as drinking, stress or depression, for example, but does not refer to their abusive behaviour, these are useful questions to ask

- "How is this drinking/stress at work/depression affecting how you are with your family?"
- "When you feel like that what do you do?"
- "When you feel like that, how do you behave?"
- "Do you find yourself shouting/smashing things……?"
- "Do you ever feel violent towards a particular person?"
- "It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would you like to assist you to make these changes?"
- **If the perpetrator has stated that domestic abuse is an issue, these are useful questions to ask:**
- "It sounds like your behaviour can be frightening; does your partner say she is frightened of you?"
- "How are the children affected?"
- "Have the police ever been called to the house because of your behaviour?"

- “Are you aware of any patterns – is the abuse getting worse or more frequent?”
- "How do you think alcohol or drugs affect your behaviour?"
- “What worries you most about your behaviour?”
- If a perpetrator responds openly to these prompting questions, more direct questions relating to heightened risk factors may be appropriate:
- "Do you feel unhappy about your partner seeing friends or family - do you ever try to stop her?"
- "Have you assaulted your partner in front of the children?"
- "Did/has your behaviour changed towards your partner during pregnancy?"

27.13 The information gathered will be the basis for a decision about how best to engage and what kind of specialist help is required - either for the perpetrator or to manage risk.

28. GOOD PRACTICE IN DEALING WITH PERPETRATORS (RESPECT GUIDELINES)

- Be clear that abuse is always unacceptable
- Be clear that abusive behaviour is a choice
- Affirm any accountability shown by the abuser
- Be respectful and empathic but do not collude
- Be positive, abusers can change
- Do not allow your feelings about the abusers behaviour to interfere with your provision of a supportive service
- Be straight-forward; avoid jargon
- Be clear that you might have to speak to other agencies and that there is no entitlement to confidentiality if children are at physical or emotional risk.
- Whatever the person says, be aware that, on some level they are unhappy about their behaviour.
- Be aware, and tell the person, that children are always affected by living with domestic abuse, whether or not they witness it directly.

- Be aware, and convey to the person, that domestic abuse is about a range of behaviours, not just physical violence (see definition).

- Do not back them into a corner or expect an early full and honest disclosure about the extent of the abuse;

- Be aware of the barriers to them acknowledging their abuse and seeking help (such as shame, fear of child protection process, self-justifying anger).

- Be aware of the likely costs to the person themselves of continued abuse and assist them to see this.

- If you are in contact with both partners, always see them separately if you are discussing abuse.

28.2 **RISK ASSESSMENT**

28.1 Although risk assessment is primarily informed by the survivor's experience and insights there may be other factors identified through contact with or knowledge of the perpetrator.

28.2 Research shows that these are significant indicators of heightened risk. Risk awareness should be a continuous process and risk assessments should be regularly reviewed.

28.3 **Checklist: Risk Assessment**

- Recent or imminent separation
- Past assault of family members
- Past assault of strangers or acquaintances
- Past breach or ignoring of injunctions, court orders or conditions
- Victim and/or witness of "family" violence as child or adolescent
- Substance misuse
- Recent mental ill-health relating to violence
- Past physical assault of partner
- Partner pregnant or recently given birth
- Sexual assault or sexual jealousy
- Past use of weapons or threats of death
- Recent escalation in frequency or severity of assaults

- Extreme minimisation or denial of domestic violence history
- Attitudes that support or condone domestic abuse

28.4 Research shows that these are significant indicators of heightened risk. These considerations should inform any decision making around undertaking multi-agency consultation or risk management measures, together with agencies such as children and families social work, police or other agencies.

28.5 **SAFETY FOR THE PROFESSIONAL**

28.6 Don't work on your own – utilise your agencies policies and procedures and maintain links with other colleagues / agencies to share relevant information for the purpose of assessing and managing risk.

28.7 Ensure that you have sufficient training for this work and seek specialist advice.

28.8 **GUIDANCE ON THE IMPORTANCE OF HOLDING PERPETRATORS TO ACCOUNT**

28.9 In a public health context where perpetrators of domestic abuse are presenting and engaging with health services it is vitally important that health practitioners are aware of the impact of abuse on the mother and any children.

28.10 The Safe & Together Model provides important tools for ensuring that the perpetrator of domestic abuse is kept visible throughout the engagement.

28.11 A key concept of the Safe & Together Model is that of "pivoting to the perpetrator" in order to examine their role and the impact of their abuse on the woman presenting, and her children.

28.12 Changing practice to focus on the perpetrators pattern of coercive and abusive behaviour increases safety for women and children and keeps perpetrators in view and accountable.

28.13 The Safe & Together Model is an internationally recognized suite of tools and interventions designed to help child welfare professionals become domestic abuse-informed.

28.14 This child-centred model derives its name from the concept that children are best served when we can work toward keeping them safe and together with the non-offending parent (the adult domestic violence survivor).

28.15 The Model provides a framework for partnering with domestic abuse survivors and intervening with domestic abuse perpetrators in order to enhance the safety and wellbeing of children.

28.16 **Safe and Together Principles**

- Keeping the child Safe and Together with the non-offending parent to provide safety, healing from trauma, stability and nurturance

- Partnering with the non-offending parent as a default position is efficient, effective and child-centred

- Intervening with the perpetrator to reduce risk and harm to the child via engagement, accountability and courts.

28.17 **Safe & Together Critical Components**

- Perpetrator's pattern of coercive control

28.18 **Actions taken by the perpetrator to harm the child**

- Full spectrum of non-offending parents to promote the safety and wellbeing of the child

- Adverse impact of the perpetrator's behaviour on the child

- Role of substance abuse, mental health, culture and other soci-economic factor

28.19 There are a range of useful resources and training videos on the Safe and Together website: https://safeandtogetherinstitute.com

28.20 **Domestic Abuse Informed sample questions**

- What is the impact on the patient (mother or child) of domestic abuse perpetrated by the father?

- Where is the partner/husband/father? (if woman presents alone)

- How do we identify and document who any accompanying males are?

- How do we proceed if there appears to be any fear or reticence to speak by women accompanied to appointments?

- Do we ask the mother how the perpetrator's behaviour is affecting her children's welfare or her parenting?

28.21 There are a range of useful resources and training videos on the Safe and Together website: https://safeandtogetherinstitute.com

28.22 **REFERRAL FOR PATIENTS WHO DISCLOSE THAT THEY ARE PERPETRATING ABUSE**

28.23 It is important that Health professionals are aware of where to refer identified perpetrators:

28.24 A referral **should never be made to anger management courses**. (This is a common misperception and needs to be highlighted in any policy document as it is dangerous practice).

28.25 The primary role of specialist services for perpetrators is to confront and tackle the violence.

28.26 When men are convicted of domestic violence offences they may be referred to a Probation Service male perpetrators programme, depending on the severity of the offence and their suitability for this kind of intervention.

28.27 **RESPECT NATIONAL HELPLINE**

28.28 The national Respect phone line is a confidential helpline, email and webchat service for perpetrators of domestic violence looking for help to stop. The service helps male and female perpetrators, in heterosexual or same-sex relationships. Partners or ex-partners of perpetrators, as well as concerned friends and family members and frontline workers are also welcome to make contact for information, advice and support.

28.29 Resources:

- http://respect.uk.net/information-support/domestic-violence-perpetrators/

- http://respectphoneline.org.uk/help-information/frontline-workers-and-domestic-violence-perpetrators/resources-for-working-with-domestic-violence-perpetrators/

28.30 Respect Phone Line: 0808 802 4040 (Monday-Friday 9am-5pm. Free from landlines and mobile phones, the call will not appear on your phone bill statement). Webchat available Tuesdays and Thursdays 10am – 4pm

28.31 **LOCAL PROVISION**

28.32 Somerset Integrated Domestic Abuse Service offers support to men and women who want to change their abusive behaviour in intimate relationships and victims who wish to break the cycle of abuse.

28.33 If you would like more information, please telephone the Somerset Domestic Abuse Helpline on 0800 69 49 999.

28.34 There are a range of useful resources and training videos on the Safe and Together website: https://safeandtogetherinstitute.com

29. RECORD KEEPING

29.1 The Department of Health Document states that ‘documentation and record keeping have an important role in responding to domestic violence’. Each department/service should consider the need for recording information and the value of monitoring data in order to reinforce good practice.

29.2 Staff should clearly explain to the victim the importance of documenting their experience. Records of injuries may prove vital at a later date if they choose to prosecute the abuser. Additionally clear and concise documentation of their abuse is a helpful way of validating their experiences and demonstrates that professionals have taken seriously their account of events.

29.3 However, in order to maintain confidentiality, extreme caution should be taken when documenting domestic abuse. Safety planning should be clearly documented in the clinical notes to enable staff to follow up at a later date. Staff must ensure that medical records are well documented for the purpose of monitoring the clients/patient’s care and incidences of abuse/suspected abuse.

29.4 **Completing safe accurate records regarding abuse**

29.5 Accurate documentation, over time at successive consultations, may provide cumulative evidence of abuse, and is essential for use as evidence in court, should the need arise.

29.6 **Record clearly**:

- Date and time of incidents, if known
- If patient states that abuse is the cause of injury, preface patient's explanation by writing: "Patient states .....”. Use patients own words when possible. Avoid subjective data that might be used against the patient (for example, "It was my fault he hit me because I didn't have the kids in bed on time.").
- Describe the patients psychological state, without interpretation/judgement
- Briefly describe types or nature of abuse
- Note facts (including observations). If patient denies being assaulted, write: "The patient's explanation of the injuries is inconsistent with physical findings" and/or "The injuries are suggestive of battering."

- Record size, pattern, age, description and location of all injuries. A record of "Multiple contusions and lacerations" will not convey a clear picture to a judge or jury, but "Contusions and lacerations of the throat" will back up allegations of attempted strangling. If possible, make a body map of injuries. Include signs of sexual abuse.

- Record non-bodily evidence of abuse, such as damaged, torn or stained clothing.

- Document behaviour of partner, including spontaneous disclosures that may indicate abuse, do not interview partner.

- Record your action (e.g. information provided, referral to DV service).

- Sign and date your record. Print your name and role.

- **Include a detailed physical record**:

- Include sketches of injury sites on a body map or photographs if possible. Photographs can convey the severity of injuries and, whenever possible, photographs should be taken of all patients with visible injuries. If this is not possible at general practice then patients can be advised to have photographs taken elsewhere.

- Explain to the patient that photographs will become part of the patient's medical record and, as such, can only be released with the patient's permission.

- Obtain written consent from patient to take photographs. (Written informed consent should include the statement, "These photographs will only be released if and when the undersigned gives written permission to release the medical records.").

- The photographer should sign and date the back each photograph.

- Place photographs in a sealed envelope and attach securely to the patient's record. Mark the envelope with the date and the notation "Photographs of patient’s injuries" monitoring the client/patient’s care and incidences of abuse / suspected abuse

- Disclosure or suspicion of domestic abuse should never be recorded in client or patient held records and staff should be vigilant in ensuring that records are not left unattended as this could place the abused person in serious danger.

30. RECORD KEEPING OF PERPETRATOR DISCLOSURE

30.1 It is paramount to keep detailed records if a perpetrator discloses abusive behaviour. This is important information which will enable continuity of care.

30.2 Good records may also help in any future legal proceedings which the survivor or the police/Crown Prosecution Service may take.

30.3 Record keeping by health professionals around perpetrators has been highlighted as critical in the context of domestic homicide reviews. Often health professionals will be the only agency in contact with both survivor and perpetrator and will hold critical information.

30.4 It is crucial that the health professional is clear about recording the information. If an individual may be at risk of significant harm, this will override any requirement to keep information confidential. Refer to Legal Framework and Guidance for Information Sharing (16.1), Domestic Abuse Policy 2020.

31. RESOURCES

31.1 Specialist Organisations

31.2 http://www.safelives.org.uk/

31.3 http://www.standingtogether.org.uk/

31.4 https://www.womensaid.org.uk

31.5 https://www.imkaan.org.uk/

31.6 https://www.somersetsurvivors.org.uk

31.7 https://www.hollieguard.com

31.8 http://respect.uk.net/information-support/domestic-violence-perpetrators/

31.9 https://safeandtogetherinstitute.com

31.10 **LGBTq Domestic Violence Helpline**

31.11 http://www.galop.org.uk/galop-to-run-national-lgbt-domestic-violence-helpline/

31.12 **HONOUR BASED VIOLENCE**

31.13 https://www.refuge.org.uk/our-work/forms-of-violence-and-abuse/honour-based-violence

31.14 https://www.haloproject.org.uk/definition-of-honour-based-violence-W21page-47

31.15 https://karmanirvana.org.uk/about/honour-based-abuse

31.16 **FORCED MARRIAGE**

31.17 https://www.gov.uk/stop-forced-marriage

31.18 **FEMALE GENITAL MUTILATION**

31.19 FGM resource pack: https://www.gov.uk/government/publications/femals-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack#effective-practice-and-resources

31.20 NHS England has produced a helpful pocket guide: https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

32. REFERENCES – LEGISLATION

32.1 **HUMAN RIGHTS ACT**

32.2 Under the Human Rights Act, all public bodies have an obligation to protect the human rights of individuals and to ensure that their human rights are not being violated. Violence, domestic abuse and sexual violence against either women, girls, boys and men denies the most fundamental of human rights.:

32.3 http://www.legislation.gov.uk/ukpga/1998/42/contents

32.4 **EQUALITY AND DIVERSITY**

32.5 The Equality Act 2010 includes a public sector duty, whereby those subject to the general equality duty, must have due regard to the need to eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity for protected groups; and foster good relations.

32.6 The Care Act (2014) HMSO, London

32.7 The Children Act (1989) HMSO, London

32.8 Adoption and Children Act (2002) HMSO, London

32.9 The Crime and Disorder Act (1998). HMSO, London

32.10 Female Genital Mutilation Act (2003) HMSO, London

32.11 Domestic Violence, Crime and Victims Act (2004) HMSO, London

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32.13 Serious Crime & Disorder Act 92015) HMSO.London

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32.37 Home Office (2003, 2004 +2011) British Crime Survey

32.38 Home Office (2010b) Homicides, firearm offences and intimate violence 2009/10:

32.39 Supplementary volume 2 to crime in England and Wales 2008/09 [online].

32.40 Howard LM, Trevillion K, Khalifeh H et al. (2010) Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychological Medicine 40: 881–93

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