# Domestic Violence and Abuse Policy

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This policy supersedes all previous issues
## Version Control

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Domestic Violence and Abuse Policy

1 Introduction

This policy aims to create a framework of action within the Trust to ensure a consistent and effective multi-professional response to the Government’s drive in tackling domestic abuse. The NHS has a particular contribution to make because it is the one service that almost all victims of domestic abuse will come into contact with at some point in their lives.

90% of domestic abuse cases are committed by men against women. Women are more likely to experience repeat incidents of abuse, be frightened or be injured after an attack, and as they are usually the lead care giver at home the abuse against them affects their children. This policy acknowledges that domestic abuse can also affect men and those in same sex relationships.

Domestic abuse has been identified as a major public health issue. Studies estimate that at some time in their lives 1:4 women aged 16-59 have experienced abuse in the home. 20% of female mental health service users will be experiencing current abuse and 50-60% will have experienced abuse in the past.

Violence against women by partners is referred to as either domestic abuse or domestic violence. Throughout this guidance the term ‘domestic abuse’ is used instead of ‘domestic violence’, as the latter is often misconstrued as being physical abuse only.

Gateshead Health NHS Foundation Trust recognises the serious adverse effect that domestic abuse can have on babies and children who live in affected households and the potential for both short and long term damage to their health and development. Research suggests that in at least 40% of domestic abuse cases there is also physical and sexual abuse of children involving the same perpetrator (Mullender, 2006).

Gateshead Health NHS Foundation Trust also has a responsibility to safeguard and protect adults and recognises that victims of domestic abuse should receive the same high standard of care irrespective of age, race, gender, culture, sexuality, religion or ability and that equality underpins all its service provision.

Gateshead Health NHS Foundation Trust is committed to promoting the health and wellbeing of patients and staff and, as such, recognises that domestic abuse is a crime. The trust is therefore committed to ensuring that domestic abuse is identified and recognised, and that patients and staff are provided with information and support to minimise risk.

1.1 Context

The definition of domestic violence and abuse states:-

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

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

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

This definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. (Home Office, 2012)

Living with domestic violence and abuse raises significant public health and child protection issues. The costs in providing the services to support people experiencing domestic violence impact on the Criminal Justice System, Health Care, Social Services, Housing and Civil Legal and are estimated at some £3.1 billion per year.

‘Violence and abuse can lead to an increased risk of poor mental health, injuries, chronic physical conditions, unwanted and complicated pregnancy, sexually transmitted infections and substance misuse, and the effects can last a lifetime and into subsequent generations.’ (DOH 2010).

1.2 Incidents of Domestic Abuse

On average 112 women a year are killed by a male partner or former partner, and 22 men are killed by their partner. In the LGBT (lesbian gay bisexual and transgender) community the incidence of violence and homicide is the same roughly of that of the heterosexual community. All domestic abuse laws, policies and procedures should be gender neutral and reflect the fact that domestic violence can occur within any intimate relationship. There are sometimes assumptions made about the LBGT community which means that victims can be isolated and feel unable to seek help.

In any one year, there are nationally 13 million separate incidents of physical violence or threats of violence against women from partners or former partners. Women are much more likely than men to be the victim of multiple incidents of abuse, and of sexual violence: 32% of women who had ever experienced domestic violence did so four or five (or more) times. Approximately 11% of men who have experienced domestic abuse and 89% of women had experienced 4 or more incidents of domestic violence. One third of men killed by their intimate partner in a domestic abuse setting were killed by another man.

Older people have similar rates of domestic abuse – this might be ‘old abuse’ from a long standing relationship which has always been abusive or from new relationships formed which result in abusive behaviour. Incidence of domestic abuse in the elderly can increase from age 80 to 89 and levels of violence can be very severe. Elder abuse can encompass many things and sometimes domestic abuse can get lost in the situation. It is important not to make assumptions and keep an open mind about worrying situations in the elderly population. 250,000 people over the age of 66 are at risk of abuse of some kind which could encompass neglect, emotional abuse, physical abuse sexual or financial abuse.

54% of UK rapes are committed by a woman’s current or former partner.
1.3 **Domestic Violence and Safeguarding Children**

Working Together 2013 requires staff to be alert to the strong links between adult domestic violence and abuse, substance misuse and child abuse, and recognise when a child is in need of help, services or at potential risk of suffering significant harm.

Children may suffer both directly and indirectly in households where there is domestic violence and abuse. From 31st January 2005 section 120 of the Adoption and Children Act 2002 was amended to include ‘harm caused by the witnessing of abuse or ill treatment of another’.

Patients and/or staff may be victims of or perpetrators of domestic abuse. Hearing or seeing the ill treatment of another constitutes harm. Therefore a referral should be made to Local Authority Children’s Social Care if a child lives in a household where domestic violence is believed to be a factor which may lead to them being in need of support or protection.

Unborn children are at risk as research (Sterne and Poole, 2010) indicates that violence towards women increases both in severity and frequency during pregnancy often involving punches or kicks directed at the women’s abdomen. Once born, the impact on the mother-child attachment process may be affected, as well as the child’s capacity to develop normal responses to stressful situations. This can result in a fractious baby and place both mother and child at further risk from their abuser.

Domestic violence during pregnancy puts a pregnant woman and her unborn child in danger. It increases the risk of miscarriage, infection, premature birth, low birth weight, fetal injury and fetal death.

1.4 **The risk of domestic abuse increases during pregnancy**

- Over a third of domestic violence/abuse starts or gets worse during pregnancy
- One midwife in five knows that at least one of her expectant mothers is a victim of domestic violence
- A further one in five midwives sees at least one woman a week who she suspects is a victim of domestic abuse

Babies under 12 months old are particularly vulnerable to violence. Where there is domestic violence in families with a child under 12 months old (including an unborn child), even if the child was not present, professionals should make a referral to children’s social care if there is any single incident of domestic violence.” (Working Together 2010)

The Safeguarding Children Policy as well as Named Nurse/Midwife for Safeguarding Children can be accessed through the Safeguarding Children information on the Trust Intranet site.

2 **Policy scope**

This policy applies to those members of staff who are directly employed by Gateshead Health NHS Foundation Trust and for whom Gateshead Health NHS Foundation Trust has legal responsibility.

2.1 **Current Legislation**

- Crime and Disorder Act 1998
Domestic Violence and Abuse Policy v1

- Children Act 1989 and 2004
- Sexual Offences Act 2003
- Female Genital Mutilation Act 2003
- Forced Marriage Act 2007
- Crime and Security Act 2007
- Protection from Harassment Act 1997, amended by the Protection of Freedom Act 2012 to include 2 new offences for stalking
- Anti-Social Behaviour, Crime and Police Act 2014
- The Care Act 2014

3 Aim of policy

The purpose of this policy is to provide clear guidance supported by education and training which will enable staff to support the victims of domestic abuse. In accordance with the Mental Capacity Act 2005, we work from a presumption of mental capacity unless a person’s apparent comprehension of a situation gives rise to doubt.

When developing this policy and when developing future policies the Trust has been and will be mindful of the impact of the policy in relation to disability, race, gender, age, sexual orientation and religion.

This policy recognises that identifying domestic abuse is a regular part of healthcare assessment and promotes routine enquiry which is timely and should occur at key times, such as: initial assessment, out-patient clinics, follow-up appointments or any other appropriate time in the patient journey. This supports routine risk assessment to ensure that the safety of patients, visitors and staff is maximised.

4 Duties (roles and responsibilities)

4.1 Chief Executive
Overall accountability for implementing the Policy within Gateshead Health NHS Foundation Trust lies with the Chief Executive. The latter having the responsibility to implement in full the duties in respect of Safeguarding Adults and Children, domestic abuse being a composite part of safeguarding.

4.2 Director of Nursing, Midwifery and Quality
To ensure the implementation of all policies and procedures that are in place to maintain the safety of service users, staff and the public. Lead the development and implementation of domestic abuse policy and procedure.

4.3 Safeguarding Adults Team
Will provide the following in the context of domestic abuse:
- An expert professional leadership role in relation to Safeguarding Adults.
- Work at a strategic level across the health and the social care community, fostering and facilitating multi agency working and training in respect of Safeguarding Adults
- Act as an expert resource on Safeguarding Adult issues, providing accessible, accurate and relevant information to staff within Gateshead Health NHS Foundation Trust.
- Deliver training relating to domestic abuse to clinical areas working with adults across the Trust.
4.4 **Safeguarding Childrens Team**
Will provide the following in the context of domestic abuse:
- An expert professional leadership role in relation to Safeguarding Children.
- Work at a strategic level across the health and the social care community, fostering and facilitating multi agency working and training in respect of Safeguarding Children.
- Act as an expert resource on Safeguarding Children issues, providing accessible, accurate and relevant information to staff within Gateshead Health NHS Foundation Trust.
- Advice, support, supervision and guidance on the management of domestic abuse within the context of Safeguarding Children.
- Deliver training identifying domestic abuse and the impact on children as part of level 2 and 3 safeguarding children training.

4.5 **Strategic Safeguarding Lead**
Will be responsible for attending the scheduled MARAC, soliciting and disseminating information in support of the process and offering the appropriate advice to staff regarding disclosures of domestic abuse that may form the basis of a MARAC referral.

The Strategic Safeguarding Lead is also responsible for creating and removing MARAC flags on the Trust’s electronic Medway system. Please see section 6.8 for further information.

4.6 **Line Managers**
- To ensure that all staff under their supervision access basic awareness training on domestic abuse.
- To ensure that all staff completing clinical risk assessments will routinely ask about domestic abuse and will access relevant domestic abuse training in accordance with NICE guidance number 50.
- To ensure that staff are trained to undertake Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessments and where high risk is identified to be aware of the local MARAC processes.
- To offer the initial and appropriate advice to staff members experiencing domestic abuse.
- To provide the appropriate support to staff who have domestic abuse disclosed to them.
- To facilitate the requirement for obtaining the data in support of the MARAC and to ensure that frontline staff have received MARAC feedback from the Strategic Safeguarding Lead.

4.7 **Employees**
All staff need to be aware of the policy and how it impacts on their practice. It is the responsibility of staff to ensure they keep up to date with the contents of this policy and implement when relevant. As befits their role, staff must access training undertaking training relating to Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessments and where high risk is identified to be aware of the local MARAC processes.
5 Definitions

The following are examples of and are not an exhaustive list:

Domestic Abuse

5.1 Physical Abuse
Shaking, smacking, punching, pushing, kicking, biting, starving, tying up, stabbing, suffocation, throwing things, using objects as weapons, female genital mutilation, ‘honour violence’. The physical effects are often on areas of the body that are covered and hidden (i.e. breasts and abdomen).

5.2 Sexual Abuse
Forced sex, sexual exploitation, pressuring an individual to participate in non-consensual sexual activities, sexual insults, stopping a woman from breast feeding, coerced nudity, taking of explicit photographs under duress, sexual violence, non-consensual acts during intercourse including strangulation, beating, restraint and marking. The perpetrator may refuse to use protection and knowingly expose the victim to infection.

Indicators can be unexplained bleeding from the vagina and/or anus, unexplained genital infections, bruising around the genital area, buttocks and thighs. There may be a reluctance to be physically examined; nervous reactions and withdrawal may also be indicators.

5.3 Psychological Abuse
Intimidation, insulting, isolating the victim from friends and family, criticising, denying the abuse, treating them as inferior, threatening to harm children or take them away, forced marriage, controlling behaviour including obsessive checking of texts and whereabouts. In the LGBT community, sometimes the threat of ‘outing’ (threatening to divulge the nature of someone’s sexuality to family friends or employers) is used to intimidate individuals.

5.4 Financial Abuse
Not letting a victim work, undermining efforts to find work or study, refusing to give money, asking for an explanation of how every penny is spent, making them beg for money, gambling, not paying bills. The victim may have no access to cash or cards and have their accounts or access to money tightly controlled.

5.5 Emotional Abuse
Swearing, undermining confidence, making racist remarks, making the victim feel unattractive, calling them stupid or useless, and eroding their independence.

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
Forced Marriages and Honour Based Violence

5.6 What is honour based violence?
Honour based violence is a violent crime or incident which may have been committed to protect or defend the honour of the family or community. It is often linked to family members or acquaintances who mistakenly believe someone has brought shame to their family or community by doing something that is not in keeping with the traditional beliefs of their culture. For example, honour based violence might be committed against people who:

- become involved with a boyfriend or girlfriend from a different culture or religion
- want to get out of an arranged marriage
- want to get out of a forced marriage
- wear clothes or take part in activities that might not be considered traditional within a particular culture
- Honour is the perception of shame that can be the catalyst, and that ‘honour’ is vague and can be different things to different individuals.

Honour-based violence can include:

- Acid attacks
- Assault
- Blood feuds
- Disfigurement
- Domestic abuse
- Dowry - abuse of dowry arrangements
- False imprisonment
- Female genital mutilation
- Forced marriage
- Forced repatriation
- Harassment
- Honour killings (murder)
- Kidnap
- Stalking
- Self-harm, suicide as a result of these issues
- Rape and sexual assault

5.7 Forced Marriage
A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. This is now legislated as an offence and is recognized in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights. An arranged marriage (not considered abuse) will become ‘forced ‘if either or both parties withdraw consent and are pressured to continue with the marriage.

The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they’re bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.

5.8 Female Genital Mutilation
FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. The practice violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading
treatment, and the right to life when the procedure results in death. (World Health Organisation)

6. **Main Body of the policy**

6.1 **Key Principles**

The key principles are underpinned by the DOH publications ‘Responding to Domestic Abuse – A Handbook for Health Professionals’ and ‘Improving safety, Reducing harm – A practical toolkit for frontline practitioners’: NICE Public Health Guidance 50, Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (2014) guidance.nice.org.uk/ph50

- To ensure the safety of those abused and that of dependent children.
- To enable the healthcare professional to supply those abused with the appropriate information concerning other agencies providing support services.
- Create a healthcare environment where the abused can talk about their experience in a safe and confidential environment.
- Ensure that staff have the ability to receive disclosures of abuse and respond to such disclosures in a supportive, reassuring and appropriate manner.
- To ensure staff respond effectively to ensure compliance with the wider multi agency response to domestic abuse.
- To establish appropriate referral pathways and support for staff subjected to domestic abuse.

Any actions undertaken by Staff in respect of domestic abuse will only be undertaken with the consent of the patient unless the risk assessment identifies that there is a significant risk or a child’s health and well-being, or the capacity of the individual is such that he/she is unable to consent.

Professionals may need to escalate concerns based on their professional judgement following discussion with appropriate specialist professionals. Professional judgement should be used but the welfare of the child and the adult should be paramount. (Safeguarding Adults and Safeguarding Children Policies) (Information sharing policy)

The question about domestic abuse will be asked routinely if safe to do so, (both for the patient and the member of) as part of clinical assessment.

The outcome of this question will be documented as part of the health record.

Staff will listen and be non-judgemental. If a disclosure of domestic abuse is made the staff member will complete the DASH (Appendix 2) risk assessment tool and make written notes particularly of time, dates and persons present of/at incident/s.

6.2 **Outcome of DASH assessment:**

**High Risk** (There are identifiable indicators of risk of imminent serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm (Home Office 2002 and OASys 2006):

(‘A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible’.)
If the patient is assessed as being at high risk because of domestic abuse, the staff member must discuss the case with the Safeguarding Adults team, with a view to making a referral to the Local MARAC following the local area MARAC Pathways and IDVA service (Safer Families) at the point of referral to MARAC; (Appendix 3).

**Medium Risk** (There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, and drug or alcohol misuse)

- The staff member can contact the Safeguarding Adult Team, Local IDVA Service (Safer Families) or other Local Support Services and National Helpline on 0808 2000 247 who will advise on the local support services available for the Locality. Advise patient of wider support that is available and that you are able to facilitate access to that support (supply leaflets, contact numbers or assist in making contact).

- The staff member will discuss with the patient the potential for increased risk, because of escalating behaviours by the perpetrator.

- The staff member should seek consent from the client to enable sharing of the information with support agencies.

- When children feature or an adult at risk is present the staff member must follow the relevant safeguarding policies (Gateshead Health NHS Foundation Trust Safeguarding Children and Adult policies and relevant LSCB safeguarding procedures).

**Standard Risk** - sign post to support agencies for domestic abuse i.e. Women’s Aid. Advise the victim of the wider support that is available and that you are able to facilitate access to that support.(supply leaflets, contact numbers or assist in making contact) Ensure that the provision of this information does not place the victim at further risk and that opportunities are available for self-referral. Seek consent to inform third party agency.

The Trust is represented at the MARAC by the Strategic Safeguarding Lead. Trust staff can contact the Strategic Safeguarding Lead via switchboard, for advice and support in completing referrals.

The MARAC referral must be forwarded to the Strategic Safeguarding Lead. This will enable the correct information to be shared with the MARAC. The referring practitioner may be required to provide additional information or attend the MARAC to share relevant and proportionate information about the alleged perpetrator or alleged victim, if they are in receipt of Gateshead Health NHS Foundation Trust services or have been in 6 months prior to the MARAC.

### 6.3 Routine Enquiry

Patients should be asked routinely about domestic abuse because evidence suggests that one of the consequences of domestic abuse for victims is deterioration in their physical and mental health.

Some patients will find it difficult to disclose domestic abuse for a variety of reasons, domestic abuse information can and should be given to service users where domestic abuse is known or believed to have occurred.
If it is suspected that a serious assault has occurred, consideration must be given to protection through hospitalisation and/or a report made to the Police.

Where adults at risk are victims of domestic abuse, a referral should be made to the Safeguarding Adults Team using the guidance in the Trust Safeguarding Adults Policy.

6.4 Recording incidents of domestic abuse

Healthcare staff have a duty of care to record incidents of domestic abuse and permission to record the information need not be sought from the victim but staff should comply with current professional guidelines and, as with child protection, should include details of any given explanation and any further observations by the member of staff which contribute to the information base.

Staff should be aware that research indicates that separation from an abusive partner can increase the risk of harm as well as decrease it.

Where possible, patients should be unaccompanied when asked about domestic abuse. This allows full disclosure, if appropriate or it can facilitate information gathering and provision of advice.

Recording of domestic abuse should include any disclosure, that is, what the patient said, their emotional state and composure and a description of any injury/bruising on a body map if possible.

It is also useful to note who is present, such as a partner, when a history of an injury is being taken. If there were children in the house, were they present at any time of the alleged incident and/or present at the history taking?

The use of domestic abuse trained interpreters can be facilitated by contacting the Language Empire Interpreting Service.

6.5 Documentation

A person’s records can form part of future protection for a victim of domestic abuse. The victim may not wish to pursue a prosecution at any particular time but any recording forms part of the history of abuse and may mean that a prosecution can be brought in future.

Perpetrators of domestic abuse are assiduous in accessing information that will help them perpetuate the abuse so members of staff should try and obtain a safe correspondence address for victims where information that could put the victim at risk, can be sent.

6.6 Confidentiality

Extreme care should be taken to protect the safety of victims of abuse and no information should be disclosed which may breach their safety. For instance, a third party may try and use the whereabouts of children to trace a mother. This would apply even if the enquirer was a professional member of staff, a partner or family member who works in the system.

However, it must be made clear to patients that there are limits to the extent of confidentiality where the safety of children and vulnerable adults is concerned. Where children are living in violent households, information may be passed to other agencies in line with child protection procedures and similarly for adults, consistent with safeguarding adult’s procedures.
In cases where serious assault has occurred, it would be helpful to have the consent of the person to share information with another agency but, as with child protection and work with vulnerable adults, the welfare of the victim is paramount. If there is a serious risk to life or safety, information may be disclosed without consent.

### 6.7 Safety Planning

Following the completion of a DASH risk assessment, professionals can help minimise the risk of future domestic abuse incidents by helping victims consider and develop a personal safety plan. This helps increase the safety of the victim within the relationship or if the victim decides to leave which is clearly evidenced as a high risk point for victims of domestic abuse.

### 6.8 Flagging

All cases that are reviewed at a MARAC should be flagged by the Strategic Safeguard Lead. Each case should remain flagged as a MARAC case for a total of 12 months after the most recent MARAC review. For example, if a case is seen at a MARAC once only in January, it will be flagged for 12 months after this date. If this case is then reviewed at the same MARAC in the April of the same year, then the case will be flagged for 12 months from April.

Gateshead Health NHS Foundation Trust staff should screen for active (flagged) MARAC cases to identify repeat victims of domestic violence. If a new incident has occurred agencies should make a further referral to MARAC for that case.

### 6.9 Children

If children are living in a household and there is a known history of domestic abuse or a disclosure during the present episode of care, a Children’s cause for concern form must be completed and a referral to Children’s Social Care must be considered. This will ensure that an assessment and appropriate child protection plan (if necessary) can be made to ensure the safety of the child.

Domestic abuse is acknowledged as a primary indicator for child protection needs. Gateshead Health NHS Foundation Trust staff must refer concerns regarding child protection by contacting the relevant Children’s Social Care department and completing the Child Protection Referral form (found on the Trust intranet under Safeguarding Children. If there is real concern about the safety of a child, permission does not have to be sought from the parent prior to the referral, however it is best practice to inform parents of the referral. When a parent does comply with a referral, outcomes for children are known to improve.

### 6.10 Known domestic abuse victims who do not attend appointments

People who are known to be experiencing domestic abuse or are at risk of domestic abuse, who fail to attend appointments, should be offered a further appointment. The patient’s GP should be notified of the failure to attend an appointment.

Consideration must be given to informing other health and social care practitioners and the police of a disengagement with the Trust, as this may indicate an increase in risk of domestic abuse.
6.11 Discharge and Transfer of Care

Where a patient who is known to suffer domestic abuse is discharged from our care and treatment, a reference to their experience of domestic abuse must be included in any documentation sent to a GP or healthcare provider. This is to ensure that up to date information around domestic abuse risk is shared with other professionals who may be involved with the patient.

6.12 Domestic Violence Disclosure Scheme (Claire’s Law)

The Right to Ask: From March 8th 2014, this scheme was implemented across England and Wales, following a one year pilot. An individual can ask the police to check whether a new or existing partner has a violent past, under ‘the Right to Ask’. If records show that an individual maybe at risk of domestic abuse from a partner, the police can make a decision to disclosure information if it is legal, proportionate and necessary to do so.

The Right to Know: this enables an agency to apply for a disclosure if the agency believes an individual is at risk of domestic abuse from their partner. As above this is acted on by police if legal, proportionate and necessary to do so.

Further support is available from Gateshead Health NHS Foundation Trust Safeguarding Adult and Children team.

Please note, the police are the lead agency regarding disclosure and that staff do not give information about a potential perpetrator to the new or potential partners. This is to ensure that disclosure is undertaken safely with a risk assessment and DA support when necessary.
7. **Training**

Gateshead Health NHS Foundation Trust and its staff form part of the multi-agency process to protect victims and children from domestic abuse. To enable staff to understand their role, training needs and service delivery the following competency framework and learning and development matrix has been designed.

Gateshead Health NHS Foundation Trust has identified a set of minimum learning outcomes for each level of knowledge and skills required:

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<td></td>
<td>Staff should be trained to respond to a disclosure of domestic violence and abuse sensitively and in a way that ensures people’s safety. They should also be able to direct people to specialist services. This level of training is for: physiotherapists, speech therapists, health care assistants and receptionists.</td>
<td>Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people’s lives and the role of professionals in intervening safely. Staff should also be able to respond with empathy and understanding, assess someone’s immediate safety and offer referral to specialist services. Typically this level of training is for: nurses, accident and emergency doctors, mental health professionals, midwives, paediatricians, and alcohol and drug misuse workers.</td>
<td>Staff should be trained to provide an initial response that includes risk identification and assessment, safety planning and continued liaison with specialist support services. Typically this is for: Safeguarding nurses and midwives with additional domestic violence and abuse training, multi-agency risk assessment conference representatives and adult safeguarding staff.</td>
<td>Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse. For example, domestic violence advocates or support workers, independent domestic violence advisers or independent sexual violence advisers, refuge staff, domestic violence and abuse and sexual violence counsellors and therapists, and children’s workers.</td>
</tr>
</tbody>
</table>

8 **Equality and diversity**

The NHS Constitution states that all patients should feel that their privacy and dignity are respected whilst they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence Gateshead Health NHS Foundation Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect.
No issues have been identified in relation to the policy.

9 Monitoring compliance with the policy

<table>
<thead>
<tr>
<th>Standard/process/issue</th>
<th>Monitoring and audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in referrals to MARAC from GHNFT staff.</td>
<td>Number of MARAC referrals to be included on Performance Dashboard and to be included in Safeguarding Annual Report</td>
</tr>
<tr>
<td></td>
<td>Monitoring Committee: Safeguarding Committee, Frequency: Quarterly</td>
</tr>
<tr>
<td>Practice will be audited in the year following ratification of the policy to assess the level of practitioner understanding and action when domestic abuse is disclosed</td>
<td>Adult Cause for Concern forms will be audited on a quarterly basis for disclosures of domestic abuse to ensure that the appropriate action was taken. AN1/2 forms to be audited on a quarterly basis for disclosures of domestic abuse to ensure that the appropriate action was taken. Named Nurse and Named Midwife for Safeguarding Children</td>
</tr>
<tr>
<td></td>
<td>Monitoring Committee: Safeguarding Committee, Frequency: Quarterly</td>
</tr>
<tr>
<td>Compliance with the Domestic Abuse Training Needs Analysis</td>
<td>Numbers of staff attending Domestic Abuse training to be shared with the Safeguarding Committee.</td>
</tr>
<tr>
<td></td>
<td>Monitoring Committee: Safeguarding Committee, Frequency: Bi-Monthly</td>
</tr>
</tbody>
</table>

10 Consultation and review

This Policy will be reviewed in accordance with the following, on a when required basis:

- Legislative changes
- Good practice guidance
- Published Domestic Homicide Reviews and Serious Case Reviews
- Case Law
- Reported Significant Incidents
- New vulnerabilities
- Changes to organisational infrastructure
11 Implementation of policy (including raising awareness)

The updated domestic abuse policy will be inserted on the Trust website and Trust intranet in the policies section.

An ‘All GHNFT’ email alert will be sent informing staff of the amended policy and where it is located.

A rolling programme of Domestic Abuse training will be delivered by members of both Safeguarding teams and other senior nursing staff who have undertaken the ‘Train the Trainer’ Domestic Abuse programme.

Staff can access additional information from the Department of Health Guidance ‘Responding to Domestic Abuse – a handbook for Health Professionals’. (2005)

12 References

3. Home Office, 1999
4. Mainstreaming Gender and Women’s Mental Health: Implementation Guidance (London DoH)
5. Adoption and Children Act 2002
8. Department of Health 2010, Improving Services for Women and Child Victims of Domestic Violence
10. Department of Health 2007, Elder Abuse Study (Kings College) Biggs, Tinker and McCreadie
11. Mental Capacity Act 2005
13. Home Office 2002
14. OASys 2006
17. Home Office: Safety and Justice: sharing information in the context of domestic violence
18. Lord Darzi, 2008, High Quality for All
19. NICE public health guidance 50 – Domestic Violence and Abuse 2014
20. Working Together to Safeguard Children 2010 HM Government
21. Working Together to Safeguard Children 2013 HM Government
22. Working Together to Safeguard Children 2015 HM Government
23. World Health Organisation, definition of FGM, 2005
24. The Care Act 2014

13 Associated documentation

OP75a Safeguarding Children Policy
OP75c Safeguarding Babies Policy
OP75d Safeguarding Adults Policy
PP44 Domestic Abuse Policy (for staff)
MH28 Mental Health Act 1983 Policy
IG06 Confidentiality and Data Protection Policy
Appendix 1

Domestic Abuse Pathway Flowchart

On receipt of disclosure of domestic abuse:

1. Continue discussion in a safe and confidential environment.

2. **Listen and be non-judgemental** make written notes particularly of time, dates and persons present of/at incident/s.

3. Determine extent/nature of abuse

4. Advise person of wider support that is available and that you are able to facilitate access to that support.(supply leaflets, contact numbers or assist in making contact)

5. Seek consent to inform third party agency.

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**Is abuse real, life-threatening and/or likely to be repeated?**

- **NO**
  - Revert to 1 & 4 above. Recording incident in patient record
  - If children present or living at same address
    - Highlight disclosure in patients/child’s records via a Cause for Concern form
    - If dependent children are living with adult
      - Consent of person not required but desirable
      - Make a referral following safeguarding adult procedures

- **YES**
  - Obtain details of dependent children or children present
  - Consult with Safeguarding Adults/Childrens team – using DASH risk assessment refer to MARAC.

---

**If children present or living at same address**

- **YES**
  - Make a referral to the appropriate Children’s Social Care department
  - IF CIRCUMSTANCES SUGGEST POLICE INTERVENTION IS URGENT & NECESSARY – TELEPHONE 999
  - REMEMBER – DON’T ACT AS A DOMESTIC ABUSE CASWORKER FOR THE PERSON ONCE YOU HAVE REFERRED HIM/HER TO SOURCES OF HELP. HOWEVER, IF YOU ARE INVOLVED IN THE PATIENT’S CARE YOU MAY FORM PART OF THE RISK MANAGEMENT PLAN.

- **NO**
  - Revert to 1 & 4 above.
  - Recording incident in patient record
  - If dependent children are living with adult
    - Highlight disclosure in patients/child’s records via a Cause for Concern form
    - Make a referral following safeguarding adult procedures

Appendix 2

CAADA-DASH Risk Identification Checklist for use by IDVAs and other non-police agencies\(^1\) for identification of risks when domestic abuse, ‘honour’-based violence and/or stalking are disclosed.

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned.

Tick the box if the factor is present ✅. Please use the comment box at the end of the form to expand on any answer.

It is assumed that your main source of information is the victim. If this is not the case please indicate in the right hand column

<table>
<thead>
<tr>
<th>Q</th>
<th>Question</th>
<th>Yes (tick)</th>
<th>No</th>
<th>Don’t Know</th>
<th>State source of info if not the victim e.g. police officer</th>
</tr>
</thead>
</table>
| 1.  | Has the current incident resulted in injury?  
     (Please state what and whether this is the first injury.)                                                |            |    |            |                                                          |
| 2.  | Are you very frightened?                                                                                     |            |    |            |                                                          |
|     | Comment:                                                                                                      |            |    |            |                                                          |
| 3.  | What are you afraid of? Is it further injury or violence?  
     (Please give an indication of what you think (name of abuser(s)…) might do and to whom, including children). |            |    |            |                                                          |
|     | Comment:                                                                                                      |            |    |            |                                                          |
| 4.  | Do you feel isolated from family/friends i.e. does (name of abuser(s) …………) try to stop you from seeing friends/family/doctor or others?  
     Comment:                                                                 |            |    |            |                                                          |
| 5.  | Are you feeling depressed or having suicidal thoughts?                                                        |            |    |            |                                                          |
| 6.  | Have you separated or tried to separate from (name of abuser(s)…) within the past year?                      |            |    |            |                                                          |
| 7.  | Is there conflict over child contact?                                                                         |            |    |            |                                                          |
| 8.  | Does (……) constantly text, call, contact, follow, stalk or harass you?  
     (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.) |            |    |            |                                                          |
| 9.  | Are you pregnant or have you recently had a baby  
     (within the last 18 months)?                                                                                 |            |    |            |                                                          |
| 10. | Is the abuse happening more often?                                                                            |            |    |            |                                                          |

\(^1\) Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>11. Is the abuse getting worse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Does (……..) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being ‘policed at home’, telling you what to wear for example. Consider ‘honour’-based violence and specify behaviour.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Has (……..) ever used weapons or objects to hurt you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.</strong></td>
<td>Yes (tick)</td>
<td>No</td>
</tr>
<tr>
<td>14. Has (……..) ever threatened to kill you or someone else and you believed them? (If yes, tick who.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You □ Children □ Other □ (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Has (……..) ever attempted to strangle/choke/suffocate/drown you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Does (……..) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you know if (………..) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children □ Another family member □ Someone from a previous relationship □ Other (please specify) □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Has (………..) ever mistreated an animal or the family pet?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Are there any financial issues? For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
21. Has (……..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.)
   - Drugs □  Alcohol □  Mental Health □

22. Has (……..) ever threatened or attempted suicide?

23. Has (……..) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.)
   - Bail conditions □  Non Molestation/Occupation Order□
   - Child Contact arrangements □
   - Forced Marriage Protection Order □  Other □

24. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify.)
   - DV □  Sexual violence □  Other violence □  Other □

   Total ‘yes’ responses

**For consideration by professional:** Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim’s situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, ‘honour’- based systems and minimisation. Are they willing to engage with your service? Describe:

Consider abuser’s occupation/interests - could this give them unique access to weapons? Describe:

What are the victim’s greatest priorities to address their safety?

**Do you believe that there are reasonable grounds for referring this case to MARAC?**
   - Yes / No
   - If yes, have you made a referral? Yes/No

**Signed:**
   - Date:

**Do you believe that there are risks facing the children in the family?**
   - Yes
   - If yes, please confirm if you have made a referral to safeguard the children: Yes / No
   - Date referral made …………………………………………….

**Signed:**
   - Name:  
   - Date:
Referring agency is to complete this form with as much information as possible and forward this referral together with a copy of the completed risk indicator checklist to: gateshead.marac@northumbria.pnn.police.uk if agency has secure email.

<table>
<thead>
<tr>
<th>Date of referral:</th>
<th>Agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of referring practitioner:</td>
<td>Address:</td>
</tr>
<tr>
<td>Contact details:</td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Mobile:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

REFERRAL TO MARAC (please specify) SCHEDULED / EMERGENCY

<table>
<thead>
<tr>
<th>VICTIM</th>
<th>PERPETRATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename(s):</td>
<td>Forename(s):</td>
</tr>
<tr>
<td>Surname:</td>
<td>Surname:</td>
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<tr>
<td>Alias:</td>
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</tr>
<tr>
<td>Religion:</td>
<td>Religion:</td>
</tr>
<tr>
<td>Status of Relationship:</td>
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</table>

If Refugee / Asylum seeker (victim only)

<table>
<thead>
<tr>
<th>Nationality:</th>
<th>Status:</th>
</tr>
</thead>
</table>

GP details if known (victim only)
# VICTIM RISK ASSESSMENT ON REFERRAL

<table>
<thead>
<tr>
<th>STANDARD / MEDIUM / HIGH</th>
</tr>
</thead>
</table>

## CONSENT:

<table>
<thead>
<tr>
<th>Service User’s Consent Obtained:</th>
<th>If not can you satisfy the requirement to share information without consent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES / NO</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

## LIST ANY CHILDREN IN THE HOUSEHOLD:

1. **Name:**  
   - Date of Birth:  
   - Address:  
   - School:

2. **Name:**  
   - Date of Birth:  
   - Address:  
   - School:

3. **Name:**  
   - Date of Birth:  
   - Address:  
   - School:

4. **Name:**  
   - Date of Birth:  
   - Address:  
   - School:

## ADDITIONAL INFORMATION:

EG. Why are you referring this case to MARAC and what do you want from the process?

Background and risk issues:
Is the person referred aware of the MARAC referral?  YES / NO

If the person is aware of MARAC referral and it is safe to contact them please consider the following questions:

- Who is the victim afraid of? (to include all potential threats, and not just primary perpetrator)
- Who does the victim believe it is safe to talk to?
- Who does the victim believe it is not safe to talk to?

**REFERRAL INTO MAPPA:**  YES / NO (to be completed by MARAC Co-ordinator)

---

**Equality and Diversity information for survivor and perpetrator**

We aim to support people from all communities and by completing this section, it helps us measure which communities we are supporting.

**VICTIM**

Gender:  Male □  Female □  If you identify yourself as Transgender / Transsexual □  
Prefer not to say □

Ethnicity:  White – British □  Irish □  Other □

- Mixed – White & Black Caribbean □  White & Black African □
- White & Asian □  Other □
- Asian or Asian British – Indian □  Pakistani □  Bangladeshi □  Other □
- Black or Black British – Caribbean □  African □  Other □
- Chinese or other Racial Group – Chinese □  Other □

Religion / Belief:  None □  Christianity □  Buddhism □  Hinduism □  Judaism □  Islam □  
Sikhism □  Other □  Prefer not to say □

Disability:  Yes □  No □  Prefer not to say □

Sexual Orientation:  Lesbian / Gay □  Bi-sexual □  Heterosexual □  Prefer not to say □

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**PERPETRATOR**

Gender:  Male □  Female □  If you identify yourself as Transgender / Transsexual □  
Prefer not to say □

Ethnicity:  White – British □  Irish □  Other □

- Other □
<table>
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<th>Options</th>
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</tr>
<tr>
<td>Black or Black British</td>
<td>Caribbean □, African □, Other □</td>
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<td>Disability</td>
<td>Yes □, No □, Prefer not to say □</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Lesbian / Gay □, Bi-sexual □, Heterosexual □, Prefer not to say □</td>
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</tbody>
</table>