Promoting hope and wellbeing together

West London NHS Trust

Policy: D12
Domestic Abuse

Version:	01
Ratified by:	Trust-wide Clinical Governance Group
Date ratified:	1st October 2018
Title of Author:	Safeguarding Adult Named Professional with Contributions from Standing Together Against Domestic Violence
Title of responsible Director	Director of Safeguarding Children and Adults
Key Policy Stakeholders	Standing Together Against Domestic Violence Women and Girls Network Safeguarding Boards (Bracknell Forest, Ealing, H&F & Hounslow) Domestic Abuse Leads Safeguarding Leads Violence against Women and Girls Network Multi Agency Risk Assessment Conference (MARAC)
Date issued:	15th November 2018
Review date:	November 2021
Target audience:	All Staff
Disclosure Status	**B:** Can be disclosed to patients and the public

Equality & Diversity Statement
The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all relevant policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed.
Sustainable Development Statement
The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All relevant policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed.

Version Control Sheet

Version	Date	Title of Author	Status	Comment
01	October 2018	Safeguarding Adult Named Professional with Contributions from Standing Together Against Domestic Violence	Ratified and issued	New policy ratified at October CGG meeting 20181001

Contents

1) Ask

(The office of National Statistics (2017): Domestic Abuse is prevalent in 1 in 100 adults)

'Do you ever feel frightened by your partner or other people at home?' 'Has a partner/family member ever threatened to harm you or others including any children?'

2) Validate

'You have the right to live free from violence and abuse'
'The abuse is not your fault'
'We can help you find support'

3) Assess

Is patient (&/or their children) at imminent risk of harm?
Are they safe to go home? Where is the perpetrator? Is there anyone else at risk (children/vulnerable adults)? Has the perpetrator made any threats?

Yes

Take immediate action

- Speak to your Line Manager or Domestic Abuse Lead
- Speak to local DA service
- Speak to Safeguarding Lead or call Social Care if appropriate

Also consider:

- Consider calling 999/security
- Call the National DV Helpline 0808 2000 247 for advice/refuge space

High Risk

1) Refer to Multi Agency Risk Assessment Conference (MARAC) **CONSENT NOT REQUIRED**

- Patient should be aware
- Contact details for MARAC coordinators in each borough can be found on the Exchange

2) Refer to Independent Domestic Violence Advocacy (IDVA) **CONSENT REQUIRED**

- Local IDVA service details can be found on Trustnet

No

Is patient at high risk of significant harm or homicide?

Consider these indicators of high risk:

Separation (last 2yrs)
Pregnancy
Escalation
Cultural Isolation
Stalking & harassment
Sexual abuse

Also consider if there has been **strangulation or threats to kill**. Risk is fluid so monitor for escalation.

Consider completing a DASH RIC: the Exchange→Safeguarding→Domestic Abuse resources

Medium/Low Risk

Offer Referral to Domestic Abuse Service(s)
GET CONSENT & safe contact details

Accepted

- Check for local service details on the Exchange safeguarding pages
- Contact local service to make referral
- Establish essential safety plan (IDVA to populate in full)

Declined

- Provide information about local DA services
- National DV Helpline (0808 2000 247) / Men's Advice Line (0808 801 0327)
- Check if safe to take information away.
- Full safety plan

ARE THERE ANY CHILDREN OR ADULTS AT RISK?
Make a social care referral and inform safeguarding leads

DOCUMENT in Patient's Notes

2.0 Introduction & Background

2.1 This policy sets out West London NHS Trust's position on domestic abuse with the guiding principles and research which underlie the procedure.

2.2 The Department of Health and NHS Employers are founding members of the UK Corporate Alliance against Domestic Violence (UK CAADV). This alliance aims to encourage public and private sector employers to commit to promoting better awareness of domestic abuse. The Trust is dedicated to supporting this commitment by raising awareness of Domestic Abuse as unacceptable, a violation of Human Rights and a choice made by the perpetrator.

2.3 <u>The links between domestic abuse and mental health</u>

2.4 Domestic abuse has significant mental health consequences for survivors/victims and their children.[1]

2.5 Women with an anxiety disorder are over four times more likely to experience domestic abuse[2].

2.6 Men and women with severe mental illness are at a substantially increased risk of domestic and sexual violence (13% and 27% respectively) versus those without a severe mental illness (5% and 9% respectively)[3].

2.7 The cost of domestic abuse to the NHS is around £1.2 billion per year, with an estimated additional £176 million cost to the mental healthcare services[4].

Implications for practice: Considering the evidence base, West London NHS Trust recognises the need for a robust response to domestic abuse from Trust services. Many service users and staff will have experienced domestic abuse. Practitioners need to be equipped to spot the indicators and respond appropriately to safeguard adult and child survivors from further harm.

2.8 For more information on the links between Domestic Abuse and: Black Asian, Minority Ethnic and Refugee (BAMER) communities; Children living with Domestic Abuse; Gender; LGBTQ; intersectionality, Older People and those with caring responsibilities, please refer to the Factsheet in Appendix I.

---

[1] Howard, L., Feder, G., & Agnew-Davies, R. (2013). Domestic violence and mental health. London: RCPsych Publications.
[2] Dockerty, Colleen, Varney, Justin and Rachel Jay-Webster (November 2015) *Disability and domestic abuse- Risk, impacts and response*: (Public Health England).
[3] Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Osborn, D., Johnson, S., Howard, L. M. (2014). Domestic and sexual violence against patients with severe mental illness. Psychological Medicine, 45(04), 875-886. doi:10.1017/s0033291714001962

[4] Walby, S. (2004) *The Cost of Domestic Violence*. University of Leeds.

3.0 Scope

3.1 This policy aims to give clear instructions to all persons engaging in work with West London NHS Trust on their duties in regards to the process of managing the risks associated with domestic abuse.

3.2 The policy aims to clarify West London NHS Trust's expectations in relation to the assessing and reporting of domestic abuse and processes following a concern being raised.

3.3 It details West London NHS Trust's arrangements that ensure domestic abuse is integrated within the safeguarding structures which includes the organisation systems and clinical practice.

3.4 The policy aims to clarify West London NHS Trust's expectations in relation to staff training in domestic abuse.

3.5 To outline the process in which West London NHS Trust monitors the effectiveness of the Domestic Abuse policies and procedures.

3.6 Staff to work together to:

- Prevent or reduce the risk of harm, abuse or neglect in adults and children
- Stop abuse, harm or neglect wherever possible;
- Support adults and children to have control about how they want to live and to make choices as much as possible;
- To support service user decisions as appropriate;
- To ensure adults and children have accessible information to keep them safe;
- To support adults and children in staying safe and what to do, to raise a concern about the safety and well-being of themselves or others.

3.7 This policy details the duties and responsibilities for all persons working with West London NHS Trust, paid or voluntary, to consider the safety and welfare of all service users including children and adults (with care and support needs) in contact with the service user.

3.8 The policy applies to all employees, sub-contractors, agency workers and volunteers of the trust across all service lines, clinical and non-clinical.

3.9 All persons working in West London NHS Trust, paid or voluntary, will be required to comply with the Disclosure and Barring Service (DBS). These directions are legally binding. Failure to comply could result in employer, employee and/or volunteer

facing prosecution. The requirements and processes to be followed are detailed in the trust-wide Recruitment and Selection Policy (R6).

3.10 The DBS assists employers in making safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. The DBS includes all criminal record checks and barring decisions.

4.0 Definition

4.1 West London NHS Trust uses the cross-government definition of domestic violence and abuse, as follows:

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. The abuse can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

4.2 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.

4.3 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.

4.4 This is not a legal definition.

5.0 Duties

5.1 Chief Executive
The Chief Executive is responsible for ensuring that the trust has policies in place and complies with its legal and regulatory obligations.

5.2 Accountable Director
The accountable director is responsible for the development of relevant policies and to ensure they comply with relevant standards and criteria where applicable. They must also contain all the relevant details and processes as per P3. They are also responsible for trust-wide implementation and compliance with the policy. This duty

is delegated to and discharged through the Director for Safeguarding Children and Adults.

5.3 Managers
Managers are responsible for ensuring policies are communicated to their teams / staff. They are responsible for ensuring staff attend relevant training and adhere to the policy detail. They are also responsible for ensuring policies applicable to their services are implemented.

5.4 Policy Author
The policy author is the Safeguarding Adult Named Professional and is responsible for the development or review of this policy as well as ensuring the implementation and monitoring is communicated effectively throughout the trust via Service Line leads and that monitoring arrangements are robust.

5.5 Local Policy Leads
Local policy leads are responsible for ensuring policies are communicated and implemented within their service line as well as co-ordinating and systematically filing monitoring reports. Areas of poor performance should be raised at the service line SMT meetings.

5.6 Safeguarding Team
The Safeguarding Team will assist in implementing, monitoring and reporting on the progress of implementation, uses and outcomes related to the policy.

5.7 Domestic Abuse Leads:
Domestic Abuse Leads have been self-nominated and provided with enhanced domestic abuse training (facilitated by Standing Together against Domestic Violence) and will support staff in the implementation of the policy and procedures outlined in this policy locally.

The Leads will be provided with support by the Safeguarding team and also the local non statutory domestic abuse services.

5.8 All staff
All trust staff have duties and responsibilities in relation to the safeguarding of adults as outlined throughout this document.

6.0 Response to domestic abuse

6.1 The policy sets out four minimum standards for the West London NHS Trust's response to domestic abuse:

1. Service users should be asked about their experiences of domestic abuse.

2. **Information regarding domestic abuse must be recorded in the service user's records, within the Risk Assessment tool, Progress notes and Care Plan as appropriate.**
3. **Appropriate action must be taken in all cases where domestic abuse is identified.**
4. **Practitioners must be aware of the harm caused to children through living with domestic abuse and take appropriate safeguarding action.**

6.1 The Trust's role in Domestic Homicide Reviews (DHRs)

6.2 Domestic Homicide Reviews (DHRs) were established on a statutory basis under the *Domestic Violence, Crime and Victims Act 2004*[5]. If the trust has been involved with either a victim or perpetrator in a DHR, the trust will be asked to produce an individual management review (IMR). IMRs cannot be completed by the professional directly involved with the victim/perpetrator or the line manager of said professional. Completion of the IMR will typically fall to the service line that are or had responsibility for either the victim or perpetrator and will be signed off by their Clinical Director. For more information on DHRs, please see '*Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' by the Home Office.

6.3 The Safeguarding Adult Named Professional or the service manager will attend the Review Panels and support the communication between the agencies.

6.4 Recommendations will be directed through the Trust governance team and assigned to the appropriate person/service within five days of receiving these.

7.0 Process

7.1 A helpful mnemonic for remembering best practice is:

A- Ask
V- Validate
A- Assess
A- Action

These steps are outlined in the flowchart.

7.2 Key practice expectations:

- All members of staff recognise their responsibility to identify and respond to domestic abuse
- Staff enquiring about domestic abuse must explain to service users their role in responding to domestic abuse and what will happen following a disclosure. This will allow service users to make informed decisions.

[5] UK Government, home office. *https://www.gov.uk/government/collections/domestic-homicide-review*. [Accessed 4th October 2017]

- People presenting to frontline staff with indicators of possible domestic abuse are asked about their experiences in a private discussion
- Responses to domestic abuse put safety first and include safety planning
- People experiencing domestic abuse are offered a referral to specialist support services. Where access to services may pose a challenge, alternatives should be explored, including contacting domestic abuse/IDVA services to work out how access can be facilitated. .
- People who disclose that they are perpetrating domestic violence or abuse are offered a referral to specialist services
- Domestic abuse is discussed regularly in staff meetings and supervision so that all staff members feel confident in responding to the issue.

7.3 The Power and Control wheel (Appendix II) is a shared framework for understanding the dynamic of abusive relationships. This tool outlines the many and varied tactics that perpetrators use to establish and maintain power and control.

7.4 Table 1 lists potential indicators of domestic abuse. This is not an exhaustive list and staff should always be aware that survivors/victims of domestic abuse may present in a variety of ways. None of these indicators are absolute evidence that abuse has occurred but staff should enquire about domestic abuse when these indicators are present.

Table 1

Physical Indicators	Emotional Indicators	Behavioural Indicators	Indicators of Control
Common types of injury include: • Bruising • Broken bones • Burns or stab wounds • Chronic pain • Injuries inconsistent with explanation of cause • Multiple injuries at different stages of healing • Injuries to the breasts or abdomen • Injuries that are not consistent with the explanation. **Physical symptoms related to stress** • Self-harming behaviour • Tiredness • Poor nutrition • Cause or worsen: - Asthma - Epilepsy - Digestive problems - Migraine - Hypertension - Skin disorders **A history of:** • Recurrent sexually transmitted infections • Recurrent urinary tract infections • Repeated miscarriage or terminations • Frequent appointments with vague symptoms • Early self-discharge from hospital	• Repeat presentation with depression, panic, anxiety, self-harm or psychosomatic symptoms • Attempts or plans to attempt suicide • Feelings of dependency • Sleep disturbances • Anger • Guilt • Loss of self-confidence • Loss of hope • Eating disorders • Fear • Low self-worth • Feelings of isolation • Post-traumatic stress disorder • Increasing likelihood of misusing drugs, alcohol or prescribed anti-depressants • Patient appears frightened, overly anxious or depressed	• Patient is reluctant to speak in front of partner or family member • Patient is submissive or afraid to speak in front of partner or family member • Partner or family member is aggressive or dominant, talks for the patient or refuses to leave the room • Partner or family member always attends unnecessarily • Frequent attenders. • Frequently missed appointments. • Non-compliance with treatment.	• Non-compliance with treatment • Frequent missed appointments • Patient has limited access to money, including for things like transport, leading to an enforced course of action • Patient tries to hide injuries/signs of abuse or minimise their extent

7.5 ASK Enquiry

Ask	**Routine enquiry** has to be proportionate to the nature and scale of the problem. There must be consideration of how any enquiry may increase the risk of domestic abuse and this should be considered before engaging in a domestic abuse enquiry. Where enquiries have not been completed the reason for this must be documented in the service user's notes/risk assessment.
	Asking the question- Where appropriate, enquiry about domestic abuse should first be undertaken during an initial assessment across all services. **Practitioners should ensure that they ask only when they are alone with the service user**. The presence of a partner or relative may constrain discussions or increase risk. Where alternate methods of communication are required, i.e. language, sign language etc, please ensure an independent interpreter is accessed.
	Ensure that no family member or friend is present in the room / interpreting for the patient and that there are no children present. Questions should be asked in a sensitive, supportive manner.
	Staff may need to **adapt specific questions to suit the service user's circumstances or situation**. They may be incorporated into a structured (risk) assessment where there are already, for example, questions about violence to self and others.
	The following are **examples of framing or introductory questions**: • *Because domestic abuse is so common, I always ask patients/service users about it.* • *Because domestic abuse has so many effects on physical health and mental health, it is Trust policy to ask patients about it.* • *From past experience with other patients, I'm concerned that some of the symptoms related to your physical/mental health may be the result of someone hurting you.*
	A framing question should be followed up with a more direct question: • *Do you ever feel frightened by your partner or other people at home? Or people within your close network who may not live with you?* • *Do you feel safe at home?* • *Has a partner/family member ever threatened to harm you or others including any children?* • *Have you ever been prevented from leaving the house, seeing friends, getting a job or continuing in education?* • *Is there anyone who restricts your access to finances, going out, seeing your friends/family, going to work, telephone (you can insert what may seem more appropriate on a case by case basis).* • *Do you think you are in immediate danger?*
	Questions about domestic abuse should be revisited at other points during contact with the service user so that survivors have other opportunities to disclose.
	Asking questions should be **coupled with provision of information on services available** if the service user would like information and if it is safe for them to take it.

7.6 Validate

Validate	**Responding to disclosures of domestic abuse (from the victim)** Practitioners should be supportive and non-judgemental when a disclosure has been made.
	It is extremely important when a disclosure is made that the individual feels validated (listened to and believed). **They should be informed that they have the right to live free from violence and abuse and that the abuse is not their fault.** Examples of validating statements include: "*It's really good that you have been able to say this to me today, it's not okay that someone is treating you like this. This is not your fault and we're here to help and support you. I'm now going to ask you a few more questions, to see how best we can help you.*"

7.7 Assess

Assess	When a **disclosure** of domestic abuse is made, **a risk assessment needs to be carried out immediately** in order to determine the level of risk and to build a safety/protection plan.
	You should also **immediately obtain safe contact details** for the service user in case you are interrupted, called away, or in case they need to leave suddenly.

7.8 Assessing immediate risk- urgent response

Assess **Urgent Response**	**In order to assess risk staff must consider the following questions:** • Is it safe for the service user to return home today? • Do staff or the service user have any immediate safety concerns? • Are there any imminent threats to safety, including that of any children or other persons? • Does the service user have a place of safety?
	If it is considered that **someone is at immediate risk, an urgent response must be actioned.** In this instance staff must complete the following actions immediately: • Identify the immediate needs and wishes of the service user ensuring you have attended to their mental health/physical needs. • Inform your line manager/senior staff and seek support from a Domestic Abuse Lead or Safeguarding Team as appropriate. Follow guidelines as per these discussions. This may involve contact with Children's Services (Multi Agency Safeguarding Hub, Emergency Duty Team), Adult safeguarding services. • Refer to an Independent Domestic Violence Advisor (see the Exchange Safeguarding page for details of agencies) who can support with immediate safety/protection planning. If the service user does not consent to this support/encourage them to contact the IDVA service themselves when they are ready to do so. • Consider whether immediate police involvement is required. This is likely to be a rare occurrence but must be considered if there is risk of serious harm/injury or death to a child / or an adult and immediate safety on leaving the building cannot be assured. The police can also be contacted if the service user wants to report the domestic abuse whilst attending the service. • Consider if refuge or temporary accommodation is required. The National Domestic Violence helpline (0808 2000 247) or your local IDVA service can advise on whether there is any refuge accommodation available. Emergency temporary accommodation, if eligible, is accessed through the local authority housing options service. Shelter provides independent housing advice.

7.9 Assessing the ongoing risk- Standard response

Assess Standard Response	If the case does not require an urgent response then a standard response is completed (see below). This is **where there are no imminent or immediate concerns for safety**; however the risk may still be high.
	Trust staff should always **consider the level of risk to the survivor and any children or adults at risk in the home. Risk around domestic abuse is not static and may change over time**. There are several means by which to assess risk: 1. Professional judgement should inform all risk assessment. Staff should consider whether the service user is at high risk of further harm or death whilst taking into consideration the service user's own perception of risk. **2.** The SafeLives Domestic Abuse, Stalking and Honour-based violence (DASH) Risk Indicator Checklist (RIC) is an evidence based risk assessment tool. Wherever possible, staff should use this tool following a disclosure of abuse. This assessment tool can be found in the exchange (safeguarding page- Domestic Abuse) and can also be used as a reference list to guide assessment. The tool includes guidance on its use.

7.10 Action

Action	Practitioners must be supportive to the service user in the decisions that they choose to make**. Never advise a service user to leave the abuser**. It is important that an individual reaches their own decision on what they want to do and that if they do choose to leave that they are supported in doing this (ideally by a specialist domestic abuse organisation). Separation is a time of increased risk for both the victim and other family members.
	Very High Risk cases: Multi-Agency Risk Assessment Conference (MARAC) A very high risk case can be identified by: • Professional judgement • Visible high risk, i.e. scoring 14+ on SafeLives DASH RIC • **Referral Criteria for Repeat Victimisation:** If the victim/survivor has been referred to the MARAC in the last 12 months and there has been at least one further domestic abuse incident by the same perpetrator on the same victim/survivor since the referral. • **POTENTIAL ESCALATION OF RISK**: There have been 4 (Different MARAC areas will have a different number of incidents that meet the criteria for Potential Escalation) domestic violence incidents by the same perpetrator on the same victim/survivor in the last 12 months and they are increasing in severity or frequency
	MARAC is a multi-agency meeting that convenes in each borough (the MARAC referral should be made to the borough/area where the alleged victim/survivor resides) to increase safety and reduce risk in high risk domestic abuse cases by: 1. Sharing information on high risk cases 2. Formulating a multi-agency survivor-centred safety plan

	Practitioners from any agency can refer cases. Service users cannot self-refer. Consent of the service user is preferred but not required for a MARAC referral to be made. **The perpetrator of abuse should not be informed of the MARAC Referral/if there is any uncertainty over who the primary victim/primary perpetrator is, neither party should be made aware until it is established as safe**
	Detailed information on the MARAC process is available in appendix III.
	Contact details for the Trust designated MARAC representatives and local MARAC coordinators are available on the Exchange.
	High Risk cases: refer to an Independent Domestic Violence Advisor (IDVA[6]) A referral to an IDVA/domestic abuse service should be offered to all service users who disclose domestic abuse or where DA is identified. Unlike MARAC referrals, service users must consent to a referral to the IDVA. **IDVA's play an extremely important role in helping to keep survivors and their families safe whilst co-ordinating a multiagency action plan.**
	All levels of risk: provide information and signpost to services **If a service user does not want support from an** IDVA and is not, at the time of assessment, considered to reach the threshold of 'very high risk' (i.e. at serious risk of further harm or homicide), staff must still follow safeguarding procedures if there are children/other adults at risk, or if the service user themselves is an adult with care and support needs. Risks around this will need to be continually monitored and reviewed. However, if there are no safeguarding concerns it is important that the service user's wishes are respected. Staff members should let the service user know that they can revisit this discussion at any stage.
	Staff can consider the following; • Provide information about local domestic violence services (details on the exchange – Safeguarding page. The Women's Aid Survivors Handbook (*https://www.womensaid.org.uk/the-survivors-handbook/*) is a useful guide on available support) • Provide the National Domestic Violence Helpline (0808 2000 247) • If safe to do so, give the service user resources with numbers and information. For resources that are easier to understand for those with learning disabilities or communication difficulties please see 'Books Beyond Words' listed in the 'Domestic Abuse Services and Resources' section at the end of this policy) • Provide information about counselling services • Provide details of local substance misuse services • Carry out basic safety planning with the service user (examples can be found in appendix IV)

Staff must always ensure it is safe for a survivor to take home any information or resources

[6] An IDVA is independent from statutory agencies. They will work with survivors to assess the level of risk, discuss a survivor's options and support them to make safety plans. IDVAs can support survivors with housing, criminal and civil options, benefits, counselling etc. IDVAs are non-judgmental and non-directive with a goal of empowering a survivor to make their own decisions.

7.1.1 Assessment of risk and referral for children and young people

7.1.2 Safeguarding Children Procedures must be followed in all cases where there may be a risk to their mental/physical health or development. **All children who are around persistent domestic abuse will be impacted (irrespective of whether they observe the behaviour, whether there is physical violence, whether they are reported to be asleep etc.). They can also be used by the perpetrator to control the victim. If you are unsure of the impact, discuss with a children's safeguarding lead.**

7.1.3 The Barnardo's risk assessment tool (located on the exchange- Safeguarding Page) and here: *http://www.barnardos.org.uk/resources/research_and_publications/barnardos-domestic-violence-risk-identification-matrix/publication-view.jsp?pid=PUB-2380*) and sample safety plan (appendix IV) may be used to help establish levels of risk to children. It is a helpful tool for use in supervision. You must always refer to Children's Services where there is:

- a high risk to the victim
- any indication that the children have suffered or are at risk of suffering significant harm

and where there is any level of risk plus:

- A pregnant woman
- A baby aged 12 months or less
- A child who is disabled
- The victim does not have mental capacity

7.2.1 Adults at risk

7.2.2 The safeguarding adult duty applies to a person over 18 who:

- has care and support needs (whether or not those needs are being met by the Local Authority or Trust)
- is experiencing, or is at risk of, abuse or neglect
- 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

7.2.3 Safeguarding Adults Procedures must be followed if these provisions apply in the context of domestic abuse. Where a staff member is uncertain whether a referral needs to be made they should contact the local or trust adult safeguarding lead.

7.3.1 Domestic abuse and adult safeguarding concerns

7.3.2 Findings from domestic homicide reviews indicate that domestic abuse can go un-identified when co-presenting with adult safeguarding concerns. It is particularly important for staff to be alert to this where an intimate partner or family member may also have caring responsibilities.

7.3.3 If a victim or perpetrator is identified within a context of caring responsibilities, the procedures outlined in this policy alongside adult safeguarding procedures should be followed.

7.4.1 Service User discloses sexual abuse in a domestic abuse context

7.4.2 If a service user, employee or family member discloses sexual abuse from an ex-partner, partner or family member the above procedures should be followed. However, additional support can be offered through The Haven. The Haven is a network of specialist sexual assault referral centres (SARCs) located across London which provide 24 hour support.

7.4.3 For more information on support for survivors of sexual abuse please see: *https://www.thehavens.org.uk/referrals/*.

7.5.1 Perpetrators

7.5.2 Staff should be aware of potential indicators that a service user is using abusive behaviour:

- Presenting with injuries consistent with perpetrating abuse (such as cuts/bruising on the knuckles or scratches to the face/body which could be defensive from the victim)
- Disclosures relating to issues of management of anger (although when explored these are usually directed to very specific people as opposed to uncontrolled anger).
- Witnessing controlling or abusive behaviours (in clinic, waiting room etc.)

A disclosure of domestic abuse may occur spontaneously or as a result of direct questioning.

7.5.3 If a disclosure of domestic abuse is made by a perpetrator:

Do:

- Acknowledge any disclosure as an important step towards accessing support to change behaviour.
- Be respectful but do not collude. Abusive behaviour is a choice and a perpetrator can choose to stop. Domestic abuse is unacceptable and many behaviours are against the law.
- Give the patient the Respect Phoneline number (0808 802 4040) and ensure they understand that this is a confidential information and advice line for people worried about their abusive behaviour.

Do not:

- Assume that there is a causal relationship between a person's mental health issues and their abusive behaviour.

- Assume that accessing help for substance misuse will stop a person's violent or abusive behaviour. Support for substance misuse should occur alongside help to address the abusive behaviour.
- **Assume that anger management, individual or couples counselling are appropriate. These are potentially dangerous interventions where there is domestic abuse.**
- Assume that medication is the solution.
- Discuss the issue in joint appointments with the victim and perpetrator.

7.5.4 Staff should make a MARAC referral (appendix V) if they believe the perpetrator's behaviour places a victim at high risk of serious harm or homicide irrespective of whether the victim is their service user. The perpetrator should not be made aware of the MARAC referral. The service user/victim/survivor should normally be told about the referral even if they do not consent to it, unless this might increase the risks to them or others involved.

7.6.1 Confidentiality and information sharing

7.6.2 It is important to discuss with service users the boundaries of confidentially with regards to domestic abuse**. For example, where there are safeguarding concerns for a child or adult at risk and where there are high risk behaviours a referral will be made to MARAC irrespective of consent**. **Similarly, it may be necessary to make a referral to children's/adult services without the agreement of the service user**. However, it is very important to clarify that this is not a punitive measure but a means by which to increase support for the family – otherwise the service user is likely to feel that they are further being victimised.

7.6.3 **For circumstances in which sharing confidential information without consent can be justified, for the purposes of preventative interventions please see the SafeLives document 'The legal grounds for sharing information' (*https://goo.gl/wVolJ4*) for guidance.**

7.6.4 The Safeguarding team work closely with local domestic abuse services to build relations and develop partnership working to improve and support service user's experience. Staff working with victims/survivors of abuse are also encouraged to work with Local Services to support this work

7.7.1 Record keeping

7.7.2 Records should be accurate, detailed and clear. They may ultimately assist a service user in living a safer life (e.g. in obtaining an injunction or court order against a perpetrator). Records may also be used in criminal proceedings where a perpetrator of violence faces charges. Documentation should be as detailed as possible. Avoid the use of statements such as 'the service user was assaulted'. Instead, where possible, use the direct words of the victim. Document in a factual / neutral manner.

7.7.3 A record should be made of all injuries. Where training has been provided, use drawings or body maps. To maintain confidentiality, care needs to be taken to ensure that any recording of domestic abuse should be kept in records that a perpetrator will not be able to access.

7.7.4 **Consent is not required to record a disclosure of domestic abuse**. Health professionals should clarify that there is a duty of care to record disclosures. Letters and assessments that are copied to the service user should never mention the domestic abuse as this may increase the risk to the service user.

7.7.5 Professional record keeping processes should be adhered to for domestic abuse documentation. A domestic abuse data set for notes should include;

- Routine enquiry and the response
- If staff suspect domestic abuse but don't get a disclosure, documentation of the concerns and the reasons behind them
- Name, date of birth and relationship to perpetrator
- Whether the woman (if female) is pregnant
- Presence of children in or regularly attending the household (and their ages) or presence of adults at risk
- Nature of violence and injuries (psychological and/or physical)
- History of abuse; whether first episode, and if not – what frequency over what period (reference to specific incidents)
- Enhanced risk factors and results of risk assessments done (e.g. DASH RIC, DV RIM)
- Indication of information provided on local sources of help and indication of any action taken, for example referrals made
- Make note of any referrals made without consent and clearly document the basis for doing so
- Information received from other agencies through MARAC for example should be stored in a third party section that is not available to the service user.

IF YOU HAVE ANY DOUBTS OR CONCERNS AROUND DOMESTIC ABUSE ALWAYS DISCUSS WITH YOUR LINE MANAGER/DOMESTIC ABUSE LEAD/SAFEGUARDING LEAD

7.8.1 Where a member of staff discloses domestic abuse, the Trust will maintain appropriate confidentiality and respect. The staff member can either self-refer to their local IDVA service or can receive support from their manager and/or local domestic abuse lead as necessary to support them in the workplace.

8.0 Training and Supervision

8.1 Domestic Abuse is incorporated within the Safeguarding Children and Adult Training.

8.2 There is currently no statutory guidance/legislation to report the training requirements. However, the Trust is aware of the need to ensure staff are able to enquire and respond to domestic abuse. The research evidences the necessity of training when conducting enquiries into domestic abuse and supporting victims/survivors, the Trust will therefore review the current safeguarding training programme to ensure Domestic Abuse is strengthened within this. However, this is not a substitute for dedicated domestic abuse training and subsequently the Trust will source training from external agencies to promote and support this, where possible.

8.3 Safeguarding is integral to supervision and this includes considering discussing domestic abuse. The supervision record should demonstrate Safeguarding and domestic abuse is considered for all service users and the practice is supported and promoted.

8.4 The Safeguarding Leads and Domestic Abuse Leads will support the application of and raising the awareness of safeguarding and domestic abuse in their local areas.

9.0 Monitoring

9.1 This policy will be reviewed every two years via the Trust-wide Safeguarding Forum.

9.2 Revisions in the intervening period can be made in light of new Guidance or information relevant to the policy and clinical practice supporting it.

9.3 The delivery of this policy and ensuring compliance will be achieved through: Providing a structured programme of training (strengthening the current safeguarding training), from the point of induction of all new staff to refresher training in accordance with Trust matrix of mandatory training requirements (see M12 Mandatory Training Policy), and the provision of specific training for staff in particular settings and the take-up of training via the Local Safeguarding Adult Partnership Boards' training programmes.

9.4 The Service Lines should ensure that the policies and procedures related to Domestic Abuse and training requirements are achieved.

9.5 The trust will engage actively with all the Local Safeguarding Partnership Boards across all the London Boroughs and other localities that it serves e.g. Bracknell Forest and non-statutory domestic abuse services.

10. Fraud Statement

10.1 Not applicable to all policies (N/A)

11. References (external documents)

This policy should be read in conjunction with the following:

- *The Care Act 2014*
- *Working Together Guidance 2018*
- *Children Act 1989*

12. Supporting documents (trust documents)

- *Incident Reporting policy*
- *Disciplinary procedures policy*
- *Safeguarding Adults policy*
- *Safeguarding Children policy*
- *Clinical risk policy*
- *Information sharing policy*

13. Glossary of terms / acronyms

MARAC	MULTI-AGENCY RISK ASSESSMENT CONFERENCE
IDVA	INDEPENDENT DOMESTIC VIOLENCE ADVISOR
NICE	NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE
HM GOVERNMENT	HER MAJESTY'S GOVERNMENT
FGM	FEMALE GENITAL MUTILATION
CSU	CRISIS STABILIZATION UNIT
SMT	SENIOR MANAGEMENT TEAM
CIG	CLINICAL IMPROVEMENT GROUP
SAM	SAFEGUARDING ADULTS MANAGER
BAMER	BLACK, ASIAN, MINORITY, ETHNIC AND REFUGEE SURVIVORS
FORWARD	FOUNDATION FOR WOMEN'S HEALTH AND DEVELOPMENT

LGBT	LESBIAN GAY BISEXUAL TRANSGENDER
PTSD	POST TRAUMATIC STRESS DISORDER
GUM	GENITOURINARY MEDICINE
MASH	MULTI AGENCY SAFEGUARDING HUB
EDT	EMERGENCY DUTY TEAM
SARC	SEXUAL ASSAULT REFERRAL CENTRE
DHR	DOMESTIC HOMICIDE REVIEW
IMR	INDIVIDUAL MANAGEMENT REVIEW
AVA	AGAINST VIOLENCE AND ABUSE

14. Further Reading

Information sharing

- Safelives: The legal grounds for sharing information- *http://www.safelives.org.uk/sites/default/files/resources/Legal%20Grounds%20for%20Sharing%20Information%20Guidance.pdf*
- Information Sharing: Guidance for Practitioners and Managers H M Government 2008- *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417696/Archived-information_sharing_guidance_for_practitioners_and_managers.pdf*
- The Data Protection act 1998
- The Crime and Disorder Act 1998
- London Child Protection Procedures 2015

Domestic Abuse and Mental Health

The organisation AVA (Against Violence and Abuse) provide free online training tools:

https://avaproject.org.uk/ava-training/elearning/

15. Appendices

Appendix I: Factsheet

77% of women accessing domestic abuse services in England and Wales have suffered from Post-Traumatic Stress Disorder (PTSD) which was positively correlated to the severity of abuse experienced[7].

Domestic Abuse, Mental Health and the Black, Asian, Minority Ethnic & Refugee (BAMER) Communities

Violence Against Women and Girls is a major cause of mental illness for women, with some forms such as FGM, honour-based abuse and forced marriage more likely, but not exclusively, experienced by women in the BAMER communities.

i. 21% of women accessing specialist BAMER domestic abuse services have experienced forced marriage[8]. Forced marriage can involve abuse from both family members and spouses which impacts a person's mental health. People with severe mental health issues or intellectual disabilities may be at increased risk of forced marriage[9].

ii. FORWARD (Foundation for Women's Health and Development) estimates that 60,000 girls under 15 are at risk of FGM in the UK. FGM can cause significant physical and psychological injuries including pain, bleeding, risk of infection, anger, emotional distress and PTSD[10].

iii. Asian women under 35 years old are two to three times more vulnerable to suicide and self-harm than their non- Asian counterparts[11]. One study with UK Asian women found 92% of respondents identified "violence by the husband" as the main cause of suicide attempts[12].

iv. Mental health treatment use is highest among White British women aged 35-54 years, despite evidence to suggest that common mental health problems such as anxiety, depression and PTSD are more prevalent in some BAMER communities such as Black and Black British women[13]. It is also important to note that there are differences in perceptions of mental wellbeing between some BAMER communities and mental health

Implications for practice: It is crucial we recognise that barriers persist in preventing access to mental health services for BAMER women as well as our responsibility to remove these barriers. NICE guidelines on domestic abuse provide practical support to Trusts on achieving this (https://www.nice.org.uk/guidance/qs116/resources).

[7] Ferrari G., Agnew-Davies R., Bailey J., Howard L., Howarth E., Peters T.J., Sardinha L., Feder G.S. Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. Global Health Action, 8 February 2016 (29890), 1654–9716
[8] Thiara, R and Roy, S (2010) Vital Statistics: The experiences of BAMER women and children facing violence and abuse (IMKAAN).
[9] Bushra, R. et al. (2013). 'Forced marriage: implications for mental health and intellectual disability services' Advances in Psychiatric Treatment, 19 (2) 135-143; DOI: 10.1192/apt.bp.111.009316
[10] http://www.forwarduk.org.uk/wp-content/uploads/2014/12/Forward_-FGM-FAQ.pdf
[11] SONI-RALEIGH, V. (1996) 'Suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales' Ethnicity and Health, Vol. 1, No. 1, pp. 55–63
[12] Hicks, M. H., & Bhugra, D. (2003). Perceived Causes of Suicide Attempts in Asian Women Measure. PsycTESTS Dataset. doi:10.1037/t39852-000
[13] McManus, S., Bebbington, P., Jenkins, R. & Brugha, T. (2016) Mental Health and Wellbeing In England: Adult Psychiatric Morbidity Survey 2014. London: NHS Digital

Domestic Abuse and Gender

i. Both men and women can experience domestic abuse. However, women are at greater risk of homicide than men: in 2016, 44% of female homicide victims were murdered by their partner/ex-partner compared with 6% of male victims[14].

ii. Two women a week are killed by a male partner or ex-partner in England and Wales (19 per year in London).

iii. Each year thirty men are killed through domestic abuse in the UK: two thirds of these men are killed by other men[15].

iv. Domestic homicide reviews (DHRs) have consistently demonstrated that organisations, including mental health, have missed opportunities to identify and respond to domestic abuse.

Implications for practice:
Staff should receive training to recognise potential indicators of abuse. Those staff in contact with patients should ask direct questions about domestic abuse, creating opportunities for disclosure and links to appropriate support.

In congruence with the gendered pattern of domestic abuse perpetration and victimisation, West London NHS Trust will ask routinely ask service users about their experience of domestic abuse. The evidence, demonstrates domestic abuse disproportionately affects women, subsequently when asking men, due regard in identifying the victim and perpetrator with the potential for increasing risk should be considered.

Domestic Abuse in LGBTQ+ Relationships

i. Lesbian and bisexual women experience domestic abuse at a similar rate to heterosexual women (29.9%), although a third of this abuse is associated with male perpetrators[16]

ii. 49% of gay and bisexual men have experienced at least one incident of domestic abuse since the age of 16[17].

Implications for practice: Service users in LGBTQ+ relationships may face additional barriers in accessing support if they do not feel safe to be open about their sexuality with family, friends or support services. West London NHS Trust is ideally placed to identify LGBTQ+ survivors by creating opportunities for safe and confidential disclosure. West London NHS Trust will maintain good links with relevant specialist support services so that onward referral can be offered.

---

[14] ONS, 2015. Violent crimes and Sexual offences. www.ons.gov.uk [accessed 8th February 2017]

[15] Povey D (ed), 2005. Crime in England and Wales 2003/2004: supplementary volume 1: Homicide and gun crime. Home Office Statistical Bulletin. No 02/05. London: Home Office

[16] Hunt R, Fish J.2008. prescription for change: lesbian and bisexual women's health check. London: Stonewall

[17] Stonewall Health Briefing 2012. http://www.stonewall.org.uk/sites/default/files/Domestic_Abuse_Stonewall_Health_Briefing__2012_.pdf [Accessed 9th February 2017]

Safeguarding Children Living with Domestic Abuse

i. For 30% of women who experience domestic abuse, the first event occurs during pregnancy[18]

ii. In the UK around 1 in 5 children have been exposed to domestic abuse[19].

iii. In households where domestic abuse is occurring – and where children are present – the likelihood is that the children are in the same or the next room[20] (90% of cases).

iv. Experiencing domestic abuse leads to increased likelihood of behavioural or emotional problems for children[21]. Living with, witnessing or being exposed to domestic abuse has been identified as a source of 'significant harm' for children[22].

Implications for practice- Many children and young people access the Trust's services because of mental health issues stemming from witnessing / experiencing domestic abuse. WLMHT is ideally placed to identify when domestic abuse is at the root of these mental health presentations and activate appropriate safeguarding responses. WLMHT staff will also think about safeguarding the children of adults who present to the service with domestic abuse.

Domestic Abuse where there are Caring Responsibilities

i. In an analysis of 32 domestic homicide reviews (DHRs), 44% involved victims that were either cared for by perpetrators or were carers of perpetrators[23]. Many WMLHT service users will either be carers or be cared for by partners/family members.

Implications for practice- West London NHS Trust provide a service for many people who have carers or caring responsibilities (as a partner or family member rather than in a professional capacity). Under the Care Act 2014, West London NHS Trust has a responsibility to assess and respond to the needs of service users and carers, including those in relation to risk of harm from others.

Intersectionality and Domestic Abuse

[18] McWilliams, M. and McKiernan, J. (1993) Bringing it out into the open
[19] Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC
[20] Abrahams, C. (1994) The Hidden Victims: Children and Domestic Violence. London: NCH Action for Children
[21] Humphreys, C. (2006) Relevant evidence for practice (chapter 1 in C. Humphreys and N. Stanley (eds.) Domestic violence and child protection: directions for good practice.)
[22] Adoption and Children Act 2002
[23] Sharp-Jeffs, N., Kelly, L (2016) Domestic Homicide Review Case Analysis; Report for Standing Together

i. Intersectionality describes the ways in which oppressive institutions (racism, sexism, homophobia, transphobia, ableism, xenophobia, classism, etc.) are interconnected and cannot be examined separately from one another.

"I'm a black woman. I don't experience being oppressed on the basis of race today and then experience being oppressed on the basis of gender tomorrow. My experiences of oppression are always interconnected."

ii. An intersectional approach ensures we address these imbalances. It is a necessary approach in all areas of work relating to violence against women and girls.

iii. The effects of domestic abuse are far reaching with numerous significant health, psychological and social impacts for both adults and children who have experienced abuse[24]. However, there are groups within the population who are identified as more vulnerable, these include:

- Pregnant women
- New mothers
- Older people
- Teenagers
- Disabled people (Twice as many disabled women have experienced domestic abuse compared to non-disabled women[25])
- Where there are additional barriers to disclosing, reporting or accessing support (e.g. LGBT+, no recourse to public funds, language barriers, cultural isolation)

Implications for practice: WLMHT expects staff to consider the intersecting needs of survivors of domestic abuse and ensure that they provide bespoke, person-centred support.

Older People and Domestic Abuse

I. **Victims aged 61+ are much more likely to experience abuse from an adult family member than those 60 and under.**
II. Victims aged 61+ are much more likely to experience abuse from a **current intimate partner** than those 60 and under.
III. Older victims are **less likely to attempt to leave** their perpetrator in the year before accessing help.
IV. Older victims are more likely to be **living with the perpetrator** after getting support.
V. Older victims are significantly more likely to have a **disability** – for a third, this is physical (34%).[26]

Implications for practice: WLMHT expects staff to consider, how older people can access domestic abuse services, don't assume they will know what is available and long-term abuse and dependency.

[24] Department of Health, Responding to Violence against women and girls- the role of the NHS. London, Department of Health, 2010
[25] Mirrlees-Black, C. (1999) Domestic Violence: Findings from a New British Crime Survey Self-Completion Questionnaire. London, HMSO
[26] Safe Lives (2016) Spotlights Report #HiddenVictims. Safe Later Lives: Older people and domestic abuse

Appendix II – Power & Control Wheel

The Duluth (1984) model training wheel:

Appendix III – MARAC Process

DV Disclosure

- Domestic Abuse Disclosed to Front Line Worker.
- Front Line Worker Safety Plan & Offer DV Support Service.
- Assessment of Risk (Professional Judgement / Escalation / DASH RIC / Repeat case).
- If Front Line Worker considers victim/survivor is at HIGH RISK of serious harm or death from DV - Referral made to MARAC.
- Front Line Worker continues to support victim/survivor to reduce risk despite referrals elsewhere.

MARAC Referral

- Referral made by Front Line Worker to the MARAC where the Victim/Survivor lives.
- Via secure/ password protected email and MARAC Rep CC'd so they are aware.
- Victim/Survivor made aware of referral unless unsafe to do so & asked for consent.
- Front Line Worker also completes an information sharing without consent form if no consent.
- Perp NEVER informed of MARAC referral.

Forwarded to IDVA

- The MARAC Coordination Service, recevies MARAC referral and sends received receipt.
- MARAC forwards referral to IDVA Service within 2 working days.

IDVA contacts V/S

- IDVA Service to contact the Victim/Survivor to offer support whenever safe to do so.
- IDVA Service to liaise with Front Line Worker who referred if not safe to contact victim/survivor directly.

ARL Research

- Hounslow MARAC referrals to be received 11 working days before the MARAC meeting. In Ealing and H&F this is 1 week (dates can be ontained frofn the WLMHT reps)
- MARAC send the At Risk List to MARAC Reps (WLMHT) 8-10 days prior to MARAC.
- MARAC Reps(WLMHT) research all names, DoBs & address for ALL CASES.
- MARAC Reps (WLMHT) liaise with front line workers involved in cases for up to date risk info.
- Only the IDVA Service & Referring Agency to contact Victim/Survivor about the MARAC.

MARAC Meeting

- MARAC Chair reads out confidentiality agreement - ALL PRESENT sign it.
- MARAC Rep from referring agency presents case (only relevant and proportionate info on present risk).
- IDVA Service represents the victim/survivors views at the meeting.
- All MARAC Reps share relevant and proportionate info on present risk.
- All MARAC Reps offer actions to reduce risk on behalf of their agency & timescale for completion.
- MARAC Chair highlights risks, MARAC Coordinator recaps actions for each case.

After MARAC Meeting

- MARAC Coordinators securely email MARAC minutes & action plans out within 2-3 days to MARAC Reps (WLMHT).
- MARAC Reps (WLMHT) to ensure any urgent actions are underway prior to minutes being sent out. Hounslow MARAC send these out within 24hrs of the MARAC.
- IDVA Service / Front Line Worker allocated feedback to victim/survivor about actions involving them.
- All MARAC information to be stored in a confidential & restricted manner for professionals only.

MARAC Actions

- MARAC Reps to update front line workers involved with relevant & proportionate MARAC info.
- MARAC Reps to pass on actions they offered to appropriate front line workers to complete.
- MARAC Reps to flag & tag victim/survivor's file as a high risk DV case within the Progress notes, Care Plan and Risk Assessment (if safe to do so).
- All information shared at the MARAC continues to belong to the agency who shared it and can only be used for the actions agreed at the meeting.

Feedback & Ongoing work

- MARAC Reps to confirm to MARAC- A referrer will only be invited to attend if they do not have a Representative that will be attending on their behalf, In Hounslow Referrers can attend) actions have been completed within agreed timescale.
- Front Line Workers re-refer any flagged victim/survivors to MARAC if a further incident within 12 months.
- Front Line Workers continue to reduce risk & liaise with appropriate professionals as identified at MARAC.
- H&F & Ealing MARAC Steering Group to have oversight of the MARAC process and ensure Agency engagement. In Hounslow VAWG Strategy group oversees this.

Appendix IV – Basic Safety Planning

For the Service User/Victim/Survivor	
People experiencing violence will already have survival strategies they find effective. It is essential to acknowledge these and use them as guidance for your work. A safety plan is about allowing people to identify the options available to them within the context of their current circumstances. Some questions to ask in drawing up a safety plan:	
Who can you tell about the violence who will not tell the perpetrator?	
Do you have important phone numbers available e.g. Family, friends, refuges, police? Do your children know how to contact these people?	
If you left, where could you go?	
Do you ever suspect when your partner/ex-partner/family member is going to be violent? e.g. After drinking, when he gets paid, after relative's visit	
When you suspect the perpetrator is going to be violent can you go elsewhere?	
Can you keep a bag of spare clothes at a friend's or family member's house?	
Are you able to keep copies of any important papers with anyone else? e.g. passport, birth certificates, benefits book.	
Which part of the house do you feel safest in?	
Is there somewhere for your children to go when he is being violent and abusive (don't run to where your children are as your partner may harm them as well)?	
What is the most dangerous part of your house to be in when he is violent?	
Have you discussed with your children a safety plan for what they need to do during an incident (do not intervene, get away and get help)?	

Sample personal safety plan for survivors & their children

This safety plan has been adapted from a variety of existing plans. **It should be used with people who are escaping violence.** Remember it may not be safe for a person to fill in the plan and take it with them. Always offer to keep any information or documentation on your premises or ask if there is a safe person the plan can be kept with. If the survivor or perpetrator are in contact with drug and alcohol agencies, they may wish to ask additional questions about how the survivor's or the perpetrator's substance use is affecting the violence they are experiencing.

Suggestions for increasing safety - In the relationship

• I will have important phone numbers available to my children and myself.

• I can tell ….....and

…….....

about the violence and ask them to call the police if they hear suspicious noises coming from my home.

• If my children are hurt, I will tell ……..

• If I leave my home, I can go (list four places):

..... ….....

..... or …….....

• I can leave extra money, car keys, clothes, and copies of documents with.....

• When I leave, I will bring.....

• To ensure safety and independence, I can: keep change for phone calls with me at all times / keep my mobile phone on me at all times; open my own savings account; rehearse my escape route with a support person; and review safety plan on .....(date).
• When the violence begins which areas of the house should I avoid? E.g. bathroom (no exit), kitchen (potential weapons)
.....
Suggestions for increasing safety - when the relationship is over
• I can: change the locks; install steel/metal doors, a security system, smoke detectors and an outside lighting system.
• I will inform.....and ..... that my partner no longer lives with me and ask them to call the police if s/he is observed near my home or my children.
• I will tell people who take care of my children, and my children themselves, the names of those who have permission to pick them up. The people who have permission are: .....
and.....
• When I make phone calls I can use 141 so my number cannot be traced.
• I can tell..... at work about my situation and ask ..... to screen my calls.
• I can avoid shops, banks, and..... that I used when living with my abusive partner.
• If I feel down and ready to return to a potentially abusive situation, I can call.....for support.

Important phone numbers

Police..... Helpline….....
Friends..... Refuge .....

Items to take checklist

- Identification
- Birth certificates for me and my children
- Benefit books
- Medical cards for me and my children (e.g. children's "red books", school immunisation records etc)
- Phone card, mobile or change for a pay phone
- Money, bankbooks, credit cards
- Keys – house / car / office
- Keys to a friend or relative's house
- Medicine or medication for me and my children
- Driver's license
- Change of clothes for me and my children
- Passport(s), Home Office papers, work permits, national insurance numbers
- Divorce papers and legal orders
- Lease / rental agreement, house deed
- Mortgage payment book, current unpaid bills
- Insurance papers
- Address book
- Pictures, jewellery, items of sentimental value
- Children's favourite toys and/or blankets

 Any proof of abuse, notes, tapes, diary, crime reference numbers, names and numbers of professionals who know.

Developing a safety plan- for children

For staff working with children who are potentially at risk from domestic abuse, a safety plan could be discussed with the child if staff deem it is age appropriate and safe to do so. A safety plan is not a child protection plan although it has as its primary objective the protection of a child who witnessed domestic violence. It should always link to a child protection or child in need plan if there is one. The safety plan builds on the healthy strategies a child may already have been deploying to protect him/herself. The basis for safety planning is working with the child to explore exactly what happens at home when domestic violence takes place. The professional needs to be confident in building up a trusting relationship with the child and in being able to provide reassurance and guidance to the child.

Key questions that need to be asked in order to complete a safety plan:

1. Where are you when mum and dad are fighting (use pictures to assist the child to explain)	
2. Where do you go?	
3. Do you stay in the room?	
4. Can you leave the room?	
5. Do you hide? Where?	
6. How do you get help?	
7. Have you ever called the police?	
8. If so, what happened afterwards when the police had gone (you are trying to establish the risk of recriminations and punishment by the perpetrator or even by the mother, motivated by fear)	
9. Have you tried to stop the fighting?	
10. Did you get hurt?	
11. How did you feel?	
12. What about the other siblings (older, younger)? What do they do? Are you able to try and protect them?	
13. Have you told anyone else what happens at home?	
14. Is there another adult you can talk to or go to for help, safety?	
15. What makes you feel better when you think about mum and dad/boyfriend/family member fighting?	
16. Do you have a mobile phone you can use in an emergency?	

Key messages and attitudes professionals need to convey to children who witness and experience domestic abuse:

- It is right to be frightened but that doesn't make it ok
- Violence is not ok
- It is not up to them to stop it
- They are not responsible for the violence
- They have done nothing wrong
- They are not responsible for protecting their parents
- They have a right to be safe and not be afraid
- They can talk about their experience
- They will be heard, believed and understood
- They matter and their safety matters
- It is important that they go to school, play with their friends, have fun, be healthy, learn well, have ambitions

Sample personal safety plan for a child

This is my safety plan …… (name of child) and ……(name of worker)

If there are any angry actions or words in my house – I can't stop it

This is what I can do:

1. GET OUT OF THE WAY
2. Find a safe place. In my house this is ……
……..
3. If it's **SAFE**, phone the police
• The number is 999.
I will say:
• My name
• My home address …….
……..
• What's happening (i.e. someone is hurting my mum)
4. I can also get help from …… (i.e. next door)
5. Later I can talk with ……. about what happened
6. If I am hurt I will tell …….
It's OK to feel (e.g. scared, angry etc.) ……
8. The people that know about this plan are:……

Signed ……. (Child)
Mother ……..……
Professional …….. Date ……..……

If a patient or member of staff has concerns about a child being abducted, an organisation called 'Reunite' has produced a Child Abduction Prevention Guide which can be found here: *http://www.reunite.org/pages/prevention.asp*

Appendix V: Referral Form

Ealing , Hammersmith and Fulham MARAC R

MARAC Referral Form 2018.doc

Hounslow