The Royal Wolverhampton NHS Trust

OP108
Domestic Abuse Policy

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1.0 Policy Statement (Purpose / Objectives of the policy)

The purpose of this policy is to provide a safe and consistent approach to recognising and managing cases of domestic abuse within The Royal Wolverhampton NHS Trust (RWT) for our patients, to reduce the risk of serious harm and homicide through early identification for adult victims and children providing intervention for families affected by domestic abuse, using a 'Think Family' approach, meaning staff consider the parent, the child and the family as a whole when assessing the needs of and planning care packages.

Domestic abuse is more prevalent that many people think. Each year nearly 2 million people experience some form of domestic abuse, with 1.3 million female victims and 600,000 male victims. Each year 100,000 people in the UK are at imminent risk of being murdered or suffering significant harm as a result of domestic abuse (SafeLives, 2023).

Victims aged 61 years old and over are much more likely to experience abuse from an adult family member or current intimate partner than those aged 60 years old and under (SafeLives 2016).

It is important for health professionals to recognise that domestic abuse can encompass several types of abuse and is not limited to physical abuse. In a survey conducted by SafeLives it was identified that out of the survivors that experienced non-physical abuse, 91% experienced psychological abuse at some point during the relationship. Psychological abuse can cause serious harm and result in long term psychological and/or physical impacts which can affect numerous areas of the victim's life.

The Domestic Abuse Act 2021 now recognises children as victims, as research shows that children suffer multiple physical and mental health consequences because of living with domestic abuse, the child's welfare must remain paramount in cases of domestic abuse in compliance with Working Together (2018) and the Children Act 2004.

A summary of the key aims of the Domestic Abuse Act 2021 can be found on Gov.Uk Domestic Abuse Act 2021: overarching factsheet - GOV.UK (www.gov.uk)

Health services are in a key position to be able to identify victims of domestic abuse. Early recognition and support by agencies cuts the time victims and their families will live with abuse with referrals from health and police reducing the period by approx. 2 years, (SafeLives Insights National Briefing Paper Abuse Length.pdf, July 2018). This will in turn improve communities, improve lives, reduce costs and improve outcomes for children and adult victims alike. Further information about domestic abuse can be found in Attachment 1 Domestic Abuse Background Information.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflicts of Interest Policy is to be considered the primary and overriding Policy.

This policy should be read in conjunction with OP107, Safeguarding Staff

Experiencing Domestic Abuse

This policy also applies to community health services including GP VI practices.

2.0 Definitions

Adult Safeguarding Concern and Notification Form (SA1) Persons over 18 years of age who have care and support needs and are experiencing or at risk of experiencing abuse or neglect and as a result of those care and support deficits are unable to protect themselves from abuse or neglect (Care Act, 2014). The SA1 is the form completed to notify and share information with Adult Social Care when a concern is identified and requires multiagency action to be taken.

Child Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change their status or entitlements to services or protection.

Child Sexual Exploitation (CSE) Child Sexual Exploitation is a form of child sexual abuse. It can disrupt their social lives and education and cause long□term mental health problems including self-harm, attempts at suicide and relationship behaviours which can affect achieving a fulfilling life. Child Sexual Exploitation is not exclusive to any single community, race or religion. There is no culture in which sexual abuse is not a serious crime (DH 2015).

Coercive behaviour A single action or a pattern of assault, threats, humiliation and, or intimidation or other abuse that is used to harm, punish or frighten their victim. This definition includes so called “honour based violence”, female genital mutilation (FGM) and forced marriage; it is clear that victims are not confined to one gender or ethnic group (Home Office, 2013).

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

Domestic Abuse
The Statutory definition of domestic abuse as set out by Domestic Abuse Act 2021; Definition of “domestic abuse”. The definition of domestic abuse has been split into subsections to provide greater clarity on the types of abuse and the types of relationships in which domestic abuse occurs.

Section 1: Definition of “domestic abuse”
(1) This section defines “domestic abuse” for the purposes of the Domestic Abuse Act.

(2) Behaviour of a person (“A”) towards another person (“B”) is “domestic abuse” if—

(a) A and B are each aged 16 or over and are “personally connected” to each other,

And

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

(d) economic abuse (see subsection (4))

(e) psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to —

(a) acquire, use or maintain money or other property, or

(b) obtain goods or services

(5) For the purposes of this Act, A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of "personally connected", see section 2.

Section 2: Definition of "personally connected"

(1) Two people are "personally connected" to each other if any of the following applies —

(a) they are, or have been, married to each other

(b) they are, or have been, civil partners of each other

(c) they have agreed to marry one another (whether or not the agreement has been terminated)

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated)

(e) they are, or have been, in an intimate personal relationship with each other

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2))

(g) they are relatives

(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if —

(a) the person is a parent of the child, or

(b) the person has parental responsibility for the child

(3) In this section —

- "child" means a person under the age of 18 years
- "civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004
- "parental responsibility" has the same meaning as in the Children Act 1989
- "relative" has the meaning given by section 63(1) of the Family Law Act 1996

Section 3: Children as victims of domestic abuse
(1) This section applies where behaviour of a person ("A") towards another person ("B") is domestic abuse.

(2) Any reference in this Act to a victim of domestic abuse includes a reference to a child who – (a) sees or hears, or experiences the effect of, the abuse, and

(b) is related to A or B.

(3) A child is related to a person for the purposes of subsection (2) if –

(a) the person is a parent of, or has parental responsibility for, the child, or

(b) the child and the person are relatives.

(4) In this section –

- "child" means person under the age of 18 years
- "parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act)
- "relative" has the meaning given by section 63(1) of the Family Law Act 1996

Domestic Homicide Review (DHR)
This is a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect by a person to whom he or she was related or with whom he or she was or had been in an intimate personal relationship, or who was a member of the same household as the deceased.

Domestic Violence Disclosure scheme
Clare's Law - Right to Ask is a scheme that gives an individual the right to ask

police to check whether a new or existing partner has a violent past. If records show that an individual may be at risk of domestic violence from a partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

Duty of Candour
WHT recognises it has a duty of candour towards patients and their families to be transparent in relation to their treatment and care. This will include informing people about any incident when things go wrong, providing truthful information and an apology when necessary.

Emotional abuse
Includes eroding a victim's confidence and independence by constant insulting and offensive remarks, making them feel unattractive and useless (DH, 2005).

Employee
An individual who has entered into or works under (or, where the employment has ceased, worked under) a contract of employment. This includes non-permanent workers including bank staff, locum doctors and other agency workers.

Female Genital Mutilation (FGM) Female genital mutilation is a violation of the human rights of girls and women. Healthcare professionals must report to the police any cases of female genital mutilation (FGM) in girls under 18 that they come across in their work. A mandatory reporting duty requires Health and Social Care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. Further information can be sought from Attachment 2 Mandatory reporting of female genital mutilation: procedural information 2015. Please also refer to CP67 Identification and Management of Female Genital Mutilation Policy.

Financial abuse Refusing to allow a person to work or undermining their efforts to find work, demanding explanations on how money is spent, refusing to give money for basic needs, not paying bills or non-payment of debts and, or making the victim beg for money.

Forced Marriage Forced marriage is when one or both of the parties do not or cannot give consent to the marriage and pressure or abuse is used. In the United Kingdom this is recognised as a form of violence and a serious abuse of human rights.

Honour Based Abuse (HBA) Honour based Abuse is a violent crime or incident which may have been committed to protect or defend the honour of the family or community.

Local Authority Designated Officer (LADO) This person will be involved in the management and oversight of individual cases for dealing with allegations against people who work with children and vulnerable adults.

Multi-Agency Referral Form (MARF) This is completed for children and young people for whom there are concerns for their safeguarding.

Multi – Agency Safeguarding Hub (MASH) This is the single point of contact for all professionals to report safeguarding concerns.

Mental Capacity Mental capacity is the ability to make your own decisions. If you lose mental capacity the Mental Capacity Act 2005 (MCA) protects you and your rights. It is a law that applies to individuals aged 16 and over. It is important to consider mental capacity and to establish the victim's wishes, trying, wherever possible, to speak to the individual on their own to support them to speak freely. If a person who appears to have mental capacity chooses to stay in an abusive, high-risk relationship, staff must carefully consider if that person is making an "unwise decision" free from influence of the person perpetrating the harm. Whilst the decisions made by the individual may be at odds with our own views regarding safety, support options need to be explored to minimise risks as far as possible in accordance with the victim's wishes.

Multi-Agency Risk Assessment Conference (MARAC) MARAC is a process whereby information is shared on the victims who are at highest risk of harm due to domestic abuse. By completing a Safe Lives Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment the level of domestic abuse will be identified. The primary focus of MARAC is to safeguard the adult victim. The MARAC will also aim to safeguard any children and manage the behaviour of the offender. A risk focused, coordinated safety plan is drawn up to support the victim.

Physical abuse includes smacking, shaking, punching, biting, restraining by force, stabbing, suffocation, female genital mutilation and honour-based violence.

Psychological abuse includes intimidation, verbal abuse, insulting behaviour, isolating a victim from friends and family, undue criticism, threats to harm children or pets, forced marriage and cyber bullying using social networking sites, texts or emails.

Right to Know enables an agency or relevant third party i.e., a family member to apply for a disclosure if they believe that an individual is at risk of domestic violence from their partner. The police will then share information with the person who may be at risk if it is lawful, necessary, and proportionate to do so.

Sexual abuse includes forced sex and prostitution, refusal to practice safe sex, sexual insults, ignoring religious prohibitions about sex and preventing breast feeding.

Stalking and Harassment the Protection from Harassment Act makes stalking a specific offence. Stalking can be described as persistent and unwanted attention that makes a person feel pestered and harassed over a period of time. Stalking and harassment includes behaviour by one person that is directed at or towards another person making him or her feel harassed, alarmed and, or distressed. Social media and the internet can also be used as media to stalk and harass.

Violence Against Women and Girls (VAWG) any act of gender–based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivation

of liberty, whether occurring in public or private life. Recommendation 19 of the Convention on the elimination of All forms of Discrimination Against Women (CEDAW) is an expert body established to oversee equality issues for the United Nations adopted in 1979. It specifically requests "to consider family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision as prejudices and practices that may justify gender violence as a form of protection or control of women".

Volunteer A person who works for an organisation without being paid.

3.0 Accountabilities

The Chief Nurse

- Is the nominated Director/Executive Lead responsible for coordinating the management of safeguarding.
- Ensures that the Board receives sufficient assurance on the effectiveness of the service.

Head of Safeguarding/ Deputy Head of Safeguarding

- Manages the Children and Adult Safeguarding Service and provides expert leadership on all aspects of the safeguarding agenda.
- Is responsible for ensuring that the Trust has robust systems and processes in place for the protection and on-going support of adults and children.
- Supports the work generated by Wolverhampton Safeguarding Together.

Safeguarding Adults and Children's Team

- Will provide in the context of domestic abuse, expert professional leadership, advice, support, supervision and guidance on the management of domestic abuse and safeguarding adult and children concerns.
- Is responsible for training on identification of domestic abuse and the impact that it has on adults and children.
- Will act as a resource providing accessible, accurate and relevant information to all RWT staff.
- Contribute to planning and implementation across the organisation in respect of safeguarding children and adult issues.

All RWT staff and volunteers

- Ensure they are aware of the policy and how it impacts on their practice.
- Undertake training relating to domestic abuse that is relevant to their role.
- Be alert to the potential indicators of domestic abuse and act in accordance with this policy when supporting adults and children that have been affected by domestic abuse.
- Access further advice and guidance where they are unclear about the application of any aspect of this policy or associated guidance.
- Ensure that they are working in a proactive, preventative, protective manner that promotes effective multi-agency networking and action on domestic abuse.

4.0 Policy Detail

All front-line staff must undertake routine enquiry with every patient or ask selective questions. All RWT staff must undertake a DASH risk assessment if abuse is suspected, or a disclosure is made (Appendix 1 SafeLives DASH Risk Assessment) and should sign-post victims to appropriate support services and empower victims to make informed choices to help prevent the escalation of violence and safeguard themselves where possible.

4.1 Responding to Domestic Abuse

Responding effectively requires a non-judgmental and supportive attitude. Knowledge of the effects of abuse, an understanding of appropriate responses and local domestic abuse services are important. Not all victims of domestic abuse will disclose information, however you may suspect that abuse is happening based on potential indicators. For information detailing indicators of abuse see (Appendix 2 Indicators of Abuse)

4.2 Routine enquiry (RE)

Routine enquiry should form part of good clinical practice even when there are no indicators of abuse (Domestic violence and abuse: NICE Guidelines 2014). All front-line staff should undertake routine enquiry with every patient. Repeated routine enquiry increases the likelihood of disclosure. Asking all patients reduces the stigma attached to domestic abuse and creates an opportunity to educate individuals that abuse isn't necessarily just physical violence. The risk of abuse rises with pregnancy, so it is imperative for these questions to be asked during antenatal attendances. Further midwifery specific information can be accessed in the Maternity Services SOP Disclosure of Domestic Abuse. Enquiry should begin by framing the question so that the patient understands that this is a routine question asked of every patient. A suggested question for routine enquiry is 'do you feel safe at home?'. Routine enquiry should take place in a private environment and should never take place in front of any children or in front of the suspected perpetrator. If the patient is always accompanied during health appointments/attendances, health professionals should seek out opportunities to speak to the patient in private.

4.2 Safe Enquiry

When working with victims of domestic abuse, the first key principle to follow is to enquire safely about violence or abuse. Safe enquiry means ensuring the potential perpetrator is not and will not easily become aware of the enquiry. It is a cornerstone of best practice in domestic abuse. Safe enquiry has been developed following circumstances in which women and their children have been placed at risk of serious harm (and homicide) due to perpetrators becoming aware that professionals knew about their behaviour. You must ensure privacy for the person concerned and establish the level of risk posed to the individual, child or family from the information available. Research shows that victims of domestic abuse will not usually voluntarily disclose domestic abuse to a professional unless they are directly asked. However, whilst victims may be reluctant to disclose what is happening to them, often they are also hoping that someone will ask them if they are suffering even where it does not result in disclosure of abuse. Repeated enquiry on a number of occasions increases the likelihood of disclosure.

4.3 Selective enquiry

Opportunistic enquiry should be undertaken when domestic abuse is suspected. Routine or opportunistic enquiry must take place in private and in an environment where the victim feels safe. The enquiry must never take place in front of any children or in front of the suspected perpetrator. Family members must not be used as interpreters. Further guidance can be accessed via OP47 Interpreting and Communication Policy and Procedure. It is not appropriate to ask questions if the victim is intoxicated.

4.4 Asking appropriate questions

Evidence suggests that victims of domestic abuse want to be asked, and that people who are not suffering domestic abuse, do not mind being asked. It is important to ask questions in a gentle non-judgemental and non-threatening way. If staff are unable to undertake routine or selective questioning, then this must be documented in the relevant health record but never in the community handheld record (red book) or the patient's held record.

4.5 Children may find it difficult to talk about domestic abuse

If a child shares details of domestic abuse with you, it's important to:

- Listen carefully.
- Let them know they've done the right thing by telling you.
- Tell them it's not their fault.
- Say you will take them seriously.
- Don't confront the alleged abuser.
- Explain what you'll do next.

Never promise to keep what the child has told you a secret – explain that you will need to share information with other professionals in order to get them the right help and support.

4.6 Action to be taken following disclosure of domestic abuse

- Consider immediate risks e.g., if the victim is in immediate danger of serious injury or death, contact the police using 999. Immediate treatment for physical injuries may be required, and referral for further assessment or treatment.
- The individuals' rights to make informed choices about their circumstances which relate to any domestic violence and abuse experiences and their capacity to make such choices must be a consideration in line with adult safeguarding principles and practice. However, domestic violence and abuse is predominantly framed in a coercive and controlling dynamic which will have an impact on the individuals' decision making. This must be acknowledged and factored into all practitioners' thinking, discussion and action.
- The Domestic Abuse, Stalking and Honour Based Violence (DASHH) risk assessment (Appendix 1) must be completed by the staff member following a disclosure or suspicion of domestic abuse. This is a consistent and simple tool for practitioners to utilise to identify the level of risk posed to the victim. All completed DASH risk assessments must be emailed to the Safeguarding Team inbox rwh-tr.safeguarding-team@nhs.net.
- When a victim is identified as being high risk of harm, (14 or more on the DASHH risk assessment or based on professional judgement), a MARAC referral (Appendix 4 MARAC referral) must be completed electronically and

emailed to the Safeguarding Adults Team inbox rwh-tr.safeguarding-team@nhs.net. Consent is not required to complete a MARAC referral, but the victim needs to be informed in an open and transparent way.

- RWT staff should encourage and support all victims to self-report the incident of domestic abuse to the police via 101. However, if the victim is identified as being at high risk of harm and does not wish to self-report to the police, RWT staff must report the incident of domestic abuse to the police via 101, in the interests of public and patient safety.
- Consideration must be given to the safe discharge of the victim. RWT staff must consider if it is safe for the victim to return home. RWT staff should support the victim to access safe accommodation, such as refuge accommodation if required. Contact details for local support services and refuge services can be found on the Safeguarding Services intranet page.
- All victims of domestic abuse, regardless of the DASH risk assessment score, should be offered a referral to local IDVA support services. IDVA referrals can be found on the Safeguarding Services webpage and once completed, should be emailed securely to the appropriate IDVA service and the RWT Safeguarding Adults inbox rwh-tr.safeguarding-team@nhs.net.
- All victims of domestic abuse, regardless of the DASH risk assessment score, should be sign-posted to specialist community support services. A list of local support services can be found on the Safeguarding Services webpage.
- If the adult victim is identified as having care and support needs, RWT staff must consider completing an Adult Safeguarding referral. The completed Adult Safeguarding referral should be securely emailed to the appropriate Local Authority and the Safeguarding Adult's Team inbox rwh-tr.safeguarding-team@nhs.net. Wolverhampton Local Authority require safeguarding referrals to be completed electronically via an eMARF. Once the eMARF is completed and submitted you will be able to save PDF version of your submitted form. A copy of this PDF should be stored in the patient's records and emailed to the RWT Safeguarding Team inbox rwh-tr.safeguarding-team@nhs.net
- In cases of domestic abuse where children are within the household, the duty of care that any staff member has to a child or young person will take precedence over any obligation to the parent or adult carer and an electronic Multi Agency Referral Form (eMARF) must be completed. The victim needs to be informed of this referral in an open and transparent conversation giving reassurance that this is for help and support. The perpetrator must not be informed of this referral due to the risk to the victim and children.
- This process also applies to community health services including GP VI practices.
- Please see Appendix 3 Domestic Abuse Support Flowchart for a quick access guide to responding to concerns of domestic abuse.

4.7 Referral Criteria to MARAC

A MARAC referral (Appendix 4) should be completed when the risk to a victim has been assessed as high either through a DASH risk assessment (a score of 14 or more) or through professional judgement. It should also be used when an already known high risk victim has suffered a repeat incident from the same perpetrator within the last 12 months after the last MARAC hearing.

4.8 Support for Employees Experiencing Domestic Abuse.

Domestic abuse affects all sections of society and RWT recognises the need to have clear and effective responses to help minimise the impact of domestic abuse upon employees. RWT is committed to the welfare of its employees and seeks to support and assist any employee who is experiencing problems related to domestic abuse. Domestic abuse can affect work performance and the health and safety of employees. RWT has a legal responsibility to protect the health, safety, and welfare of all employees whilst at work. If an employee of RWT suffers domestic abuse, the main responsibility for support will lie with the employee's immediate line manager supported by the Human Resources Department. OP 107 Safeguarding Staff Experiencing Domestic Abuse provides guidance on supporting staff members.

4.9 Employee Accused of Domestic Abuse

If it is alleged that an employee of RWT is the perpetrator of domestic abuse, the Line Manager will seek guidance from the Human Resources Department. A referral of an allegation against an adult who works with children and/or adults with care and support needs (Attachment 3), must be completed when requested by the LADO.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Doe the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include: • • •

7.0 Maintenance

The Head of Safeguarding and Safeguarding team will be responsible for reviewing this policy to ensure it complies with legislation, professional guidance and local arrangements for safeguarding. It will be reviewed in line with Trust Policy OP01 every 3 years or following any legislative changes.

8.0 Communication and Training

Domestic Abuse training will be delivered as part of mandatory safeguarding training. An employee role will determine at what level this is required in order to ensure that they are confident and competent to carry out their responsibilities. The Trust, supported by the Corporate Safeguarding Team, will ensure that a sufficient number of internal training events and e-learning is provided, as per Mandatory Training Policy

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Compliance with mandatory training.	IMTG	IMTG	Monthly	Trust Safeguarding Group
Incident Summary Reports	Head of Safeguarding	DATIX NS SUI Report	Monthly	Trust Safeguarding Group

10.0 References - Legal, professional or national guidelines

Care Act 2014
Children Act (2004)

Her Majesty's Inspectorate of Constabulary (2015) – Increasingly everyone's business: A progress report on the police response to domestic abuse.

Home Office Domestic Abuse Act 2021

Home Office (2015) Mandatory reporting of female genital mutilation: procedural information

Mental Capacity Act 2005

NICE Violence and abuse: how health services, social care and the organisations they work with can respond effectively, NICE public health guidance 2014

NSPCC How Safe are our Children 2014

Protection of Freedoms Act 2012

SafeLives MARAC National Dataset 2014

SafeLives Spotlight #1: Older People and Domestic Abuse 2016

SafeLives Spotlight #7: Domestic Abuse and Mental Health 2019

Stonewall Gay and Bisexual Men's Health Survey 2012

Wolverhampton Over-arching Domestic Violence Protocol and Guidance 2018

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children 2018

Part A - Document Control

Policy number and Policy version: OP108 V3	**Policy Title** Domestic Abuse Policy	**Status:** Final		**Author:** Named Nurse Safeguarding Adults **Chief Officer Sponsor:**
Version / Amendment History	Version	Date	Author	Reason
	1.0	June 2017	Named Nurse Safeguarding Children	Introduction of policy
	1.2	April 2019	Named Nurse Safeguarding Children	Section 2.2 mention of Barnardo's Screening Process removed as this is no longer part of the process at RWT virtually approved
	1.3	June 2020	Named Nurse Safeguarding Children	Extension approved by Director Sponsor until August 2020
	2	June 2020	Named Nurse Safeguarding Children Named Nurse Safeguarding Adult	As per standard review frequency
	2.1	May 2021	Named Nurse Safeguarding Children, Named Nurse Safeguarding Adults	Minor amendments to pages 2 and 7
	3.0	May 2023	Named Nurse Safeguarding Adults	As per standard review frequency
Intended Recipients: Trust Wide: This policy applies to all staff members who are directly employed by RWT and for whom RWT have a legal responsibility. This includes clinical and non-clinical staff, students, and bank staff, who have contact with children, adult service users, Policy No OP108/version 2.1/TPG Virtual Approval May 2021 Page 13 carer's, families and local communities.				

Consultation Group / Role Titles and Date: Trust Safeguarding Group (TSG) April 2017 RWT Heads of Nursing May 2017 Wolverhampton Domestic Violence Forum May 2017 Wolverhampton Local Authority.	
Name and date of Trust level group where reviewed	Trust Policy Group – October 2023
Name and date of final approval committee	Trust Management Committee – October 2023
Date of Policy issue	November 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	October 2026 - Every 3 years
Training and Dissemination: delivered as part of mandatory safeguarding training, in the form of face to face and or e-learning	
To be read in conjunction with: CP41 Safeguarding Children Policy CP53 Safeguarding Adult Policy CP06 Consent Policy OP85 Information Sharing Policy OP110 Prevent OP41 Induction and Mandatory Training CP67 Identification and Management of Female Genital Mutilation Policy. RWT Maternity Safeguarding SOP Disclosure of Domestic Abuse-Maternity Process Wolverhampton Safeguarding Together (WST) Procedures Wolverhampton Domestic Violence Partnership Procedures Working Together to Safeguard Children (2018) NSPCC (2018) Children Living in families facing adversity London Department for Education, 2018 Working together to Safeguard Children Home Office Domestic Abuse Act 2021	
Initial Equality Impact Assessment (all policies): Completed Yes **Full Equality Impact assessment (as required): Completed Yes**	
Monitoring arrangements and Committee	Training compliance report presented monthly to the Trust Safeguarding Group
Document summary/key issues covered. This policy demonstrates the principle that domestic abuse is an unacceptable behaviour and that everyone has a right to live free from fear and abuse. This policy contains updated and current guidance in order to support safe practice in supporting both patients and staff where domestic abuse is identified.	
Key words for intranet searching purposes	Domestic Abuse, Domestic Violence, Safeguarding

Domestic Abuse Background Information

The Crime Survey for England and Wales (CSEW) estimated that 5.0% of adults (6.9% women and 3.0% men) aged 16 years and over experienced domestic abuse in the year ending March 2022; this equates to an estimated 2.4 million adults (1.7 million women and 699,000 men)

Domestic abuse affects the whole family, with research demonstrating that women are more likely than men to be the victim of repeated and multiple incidents of abuse. It is reported that women are assaulted approximately 35 times by a partner or ex-partner before seeking help from agencies (Wolverhampton Over-arching Domestic Violence Protocol and Guidance, 2018). More than 90% of victims who are discussed at MARAC are female, 15% are black, Asian or minority ethnic (BAME), 4% are disabled, and 1% are lesbian, gay, bisexual or transgender (LGBT) (Safe Lives, 2014).

Vulnerable groups that are more likely to be abused include: women in low income households, those who have separated, those who are divorced or single, and those with mental health difficulties. Younger people are more likely to be subject to interpersonal violence. Male victims of domestic abuse are over twice as likely as women to not tell anyone about the abuse.

Elder abuse is a growing issue across the UK; *Safe Later Lives: Older People and Domestic Abuse Spotlights Report*, 2016 estimated that in the year prior to the report approximately 120,000 individuals aged over 65 have experienced at least one form of abuse (psychological, physical, sexual or financial) and victims aged over 61 are much more likely to experience abuse from an adult family member than those 60 and under. Victims aged over 61 are also much more likely to experience abuse from a current intimate partner than those ages 60 and under.

The Safelives Spotlight report: *Safe and Well: Mental Health and Domestic Abuse 2019* Highlights that there is a link between domestic abuse and mental health problems. Mental health problems are a common consequence of experiencing domestic abuse, both for adults and children. And, this report says that people with mental health needs were more likely to have experienced each type of abuse (jealous and controlling behaviour, harassment and stalking, physical and sexual), particularly sexual abuse. Furthermore victims of domestic abuse with mental health needs were more likely to have visited their GP and the Emergency Department before accessing support for their abuse and were more likely to have issues with drug and alcohol misuse; nearly twice as many hospital-based victims/survivors had self-harmed or planned or attempted suicide (43%) than those in community services (23%). It is therefore clear that a more effective health response to domestic abuse and mental health is fundamental for the safety and well-being of victims/survivors.

Every individual's experience of domestic abuse will be unique. However, gay, lesbian, bisexual and transgender individuals are more likely to face additional

concerns around homophobia and gender discrimination. They may also be concerned that they will not be recognised as victims or believed and taken seriously. Abusers may also be able to control their victims through the threat of 'outing'.

The Impact of Domestic Abuse on Children and Young People;

Thousands of children in the UK live in homes with domestic abuse and they are at high risk of murder or serious injury. Thousands more live with less serious domestic violence every day. This has a serious impact on children, on their health and wellbeing with the impact being immediate and long lasting (NSPCC, 2014). In order for children exposed to domestic abuse to receive the help they so badly deserve, professionals need to make sure they make the link between the risk to the adult and the risk to the child, and that they act upon it. Working Together to Safeguard Children, (2015) makes it clear that safeguarding children (including the un-born child) and promoting their welfare is the responsibility of all professionals working with children.

Under the Children Act (1989) and The Care Act (2014) health services have a legal duty to safeguard children and adults from harm. The Adoption and Children Act (2002) extended the legal definition of "significant harm" to children to include harm suffered by witnessing or hearing ill treatment of others, strengthening the case for significant harm through domestic violence or the abuse of another in the household.

Children may witness domestic abuse directly, but they can also witness it indirectly by hearing the abuse from another room, seeing a parent's injuries or distress afterwards, finding disarray like broken furniture, being hurt from being nearby or trying to stop the abuse or experiencing a reduced quality in parenting as a result of the abuse. Exposure to domestic abuse or violence in childhood is child abuse (Royal College of General Practitioners and NSPCC, 2014; Holt, Buckley and Whelan, 2008).

Domestic abuse can have a serious effect on a child's behaviour, brain development and overall wellbeing. It undermines a child's basic need for safety and security and can have a negative impact on a child's development, education outcomes and mental health (Holt, Buckley and Whelan, 2008; Stanley, 2011; Szilassy et al, 2017).

Witnessing parental conflict may also increase the likelihood of a child developing risk-taking behaviour, like smoking, drug use and early sexual activity (Early Intervention Foundation, 2018).

If a child lives in a home where domestic abuse is happening, they're more at risk of other types of abuse (Stanley, 2011). However it can be difficult to tell if domestic abuse is happening, because perpetrators can act very differently when other people are around. Children who witness domestic abuse may display challenging behaviour, suffer from depression and anxiety and may not do as well at school as usual.

Children who experience domestic abuse may feel on constant alert. Signs of anxiety or fear-related behaviour include:

- Bed wetting or unexplained illness;

- Running away from home;
- Constant worry about possible danger or safety of family members;
- Aggression towards others (Early Intervention Foundation, 2018).
- Children may find it difficult to talk about domestic abuse for many reasons. They may feel ashamed, afraid, or not have the language to describe what they've experienced. If they have been living with domestic abuse since they were very young, they may not realise that it's wrong – and they may think it's their fault.

Never promise to keep what a child has told you a secret. Explain that you need to tell someone else who can help.

Domestic Abuse in Pregnancy:

Domestic abuse can start or escalate during pregnancy with the resulting death of the mother or the foetus. Around 30% of domestic abuse begins during pregnancy, while 40–60% of women experiencing domestic abuse are abused during pregnancy.

It can also be responsible for premature birth and low birth weight, both of which have subsequent long term health effects (See Appendix 8A and 8b Maternity Safeguarding SOP).

The Impact of Domestic Abuse on the NHS:

Domestic abuse costs the NHS £1.73bn, with mental health costs, estimated at an additional £176 million.

The NHS spends more time dealing with the impact of violence against women and children than almost any other agency and is often the first point of contact for women who have experienced violence. The health service can play an essential role in responding to and helping prevent further domestic violence and abuse by intervening early, providing treatment and information, and referring patients to specialist services. The NHS is in a unique position to help people who experience domestic violence to get the support they need.

Home Office

Mandatory Reporting of Female Genital Mutilation – procedural information

1. Introduction

Background

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). **It is a form of child abuse and violence against women.** FGM comprises all procedures involving partial or total removal of the external female genitalia for non-medical reasons.

Section 5B of the 2003 Act[1] introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. **The duty came into force on 31 October 2015.**

'Known' cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003[2].

Purpose and audience

The duty applies to all regulated professionals (as defined in section 5B(2)(a), (11) and (12) of the 2003 Act) working within health or social care, and teachers. It therefore covers:

- Health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes those regulated by the:
    - General Chiropractic Council
    - General Dental Council
    - General Medical Council
    - General Optical Council
    - General Osteopathic Council
    - General Pharmaceutical Council
    - Health and Care Professions Council (whose role includes the regulation of social workers in England)
    - Nursing and Midwifery Council
- teachers[3] - this includes qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions, and, in Wales, education practitioners regulated by the Education Workforce Council;
- social care workers in Wales[4].

[1] As inserted by section 74 of the Serious Crime Act 2015
[2] For more information, see sections 2.1a and 2.1b.
[3] Section 5B(11) of the FGM Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) provides the definition for the term 'teacher': ""teacher" means – (a) in relation to England, a person within section 141A(1) of the Education Act 2002 (persons employed or engaged to carry out teaching work at schools and other institutions in England); (b) in relation to Wales, a person who falls within a category listed in the table in paragraph 1 of Schedule 2 to the Education (Wales) Act 2014 (anaw 5) (categories of registration for purposes of Part 2 of that Act) or any other person employed or engaged as a teacher at a school (within the meaning of the Education Act 1996) in Wales".

The purpose of this document is to give professionals subject to the duty and their employers an understanding of the legal requirements it places on them, a suggested process to follow, and an overview of the action which may be taken if they fail to comply with the duty. It also aims to give the police an understanding of the duty and the next steps upon receiving a report.

In addition to complying with the duty, professionals should continue to have regard to their wider safeguarding responsibilities, which require consideration and action to be taken whenever there is any identified or known risk to a child, whether in relation to FGM or another matter. The process map at **annex A** shows where the duty fits within existing child safeguarding responsibilities.

A detailed Q and A is available at **annex B**.

This document should be considered in conjunction with relevant guidance on FGM and safeguarding, including Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate, and the multi-agency statutory guidance on FGM.

While the duty is limited to the specified professionals described above, non-regulated practitioners also have a responsibility to take appropriate safeguarding action in relation to any identified or suspected case of FGM, in line with wider safeguarding frameworks. More information is available in Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate.

The duty applies in England and Wales only.

[4] Section 5B(11) of the Female Genital Mutilation Act 2003 defines a "social care worker" as a person registered in a register maintained by the Care Council for Wales under section 56 of the Care Standards Act 2000.

2. Making a report

2.1 When a report must be made

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth (see section 2.1a for further information).

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply.

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. The only exception to this is if you know that another individual from your profession has already made a report; there is no requirement to make a second.

The duty does not apply in relation to at risk or suspected cases or in cases where the woman is over 18. In these cases, you should follow local safeguarding procedures. For more information, please see Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate, and/or the multi-agency statutory guidance on FGM.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

2.1a Visually identified cases – when you might see FGM

The duty applies to cases you discover in the course of your professional work.
If you do not currently undertake genital examinations in the course of delivering your job, then the duty does not change this. Most professionals will only visually identify FGM as a secondary result of undertaking another action.

For healthcare professionals, if, in the course of your work, you see physical signs which you think appear to show that a child has had FGM, this is the point at which the duty applies – the duty does not require there to be a full clinical diagnosis confirming FGM before a report is made, and one should not be carried out unless you identify the case as part of an examination already under way and are able to ascertain this as part of that. Unless you are already delivering care which includes a genital examination, you should not carry one out[5].

For teachers and social workers, there are no circumstances in which you should be examining a girl. It is possible that a teacher, perhaps assisting a young child in the toilet or changing a nappy, may see something which appears to show that FGM may have taken place. In such circumstances, the teacher must make a report under the duty, but should not conduct any further examination of the child.

2.1b Verbally disclosed cases

If you are a relevant professional and a girl discloses to you that she has had FGM (whether she uses the term 'female genital mutilation' or any other term or description, e.g. 'cut') then the duty applies. If, in the course of delivering safe and appropriate care to a girl you would usually ask if she has had FGM, you should continue to do so.

The duty applies to cases directly disclosed by the victim; if a parent, guardian, sibling or other individual discloses that a girl under 18 has had FGM, the duty does not apply and a report to the police is not mandatory. Any such disclosure should, however, be handled in line with wider safeguarding responsibilities - in England, this is likely to include referral to children's social services, and in Wales the disclosure must be immediately referred to the local authority.

Further information, including advice and support on how to talk to girls and parents/guardians about FGM, is available in the multi-agency statutory guidance on FGM.

[5] More information is available in the General Medical Council's guidance on intimate examinations and the child protection examinations section of their guidance on protecting children and young people

2.2 Timeframe for reports

Reports under the duty should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day, unless any of the factors described below are present. You should act with at least the same urgency as is required by your local safeguarding processes.

In order to allow for exceptional cases, a maximum timeframe of one month from when the discovery is made[6] applies for making reports. However, the expectation is that reports will be made much sooner than this.

A longer timeframe than the next working day may be appropriate in exceptional cases where, for example, a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the child (or another child, e.g. a sibling) and considers that consultation with colleagues or other agencies is necessary prior to the report being made. If you think you are dealing with such a case, you are strongly advised to consult colleagues, including your designated safeguarding lead, as soon as practicable, and to keep a record of any decisions made. It is important to remember that the safety of the girl is the priority.

2.3 Making a report

Where you become aware of a case, the legislation requires you to make a report to the police force area within which the girl resides. The legislation allows for reports to be made orally or in writing.

When you make a report to the police, the legislation requires you to identify the girl and explain why the report is being made. While the requirement to notify the police of this information is mandatory and overrides any restriction on disclosure which might otherwise apply, in handling and sharing information in all other contexts you should continue to have regard to relevant legislation and guidance, including the Data Protection Act 1998 and any guidance for your profession. The provisions of the Data Protection Act 1998 do not prevent a mandatory report to the police from being made.

While the legislation requires a report to be made to the police, it does not specify the process for making the report. If you have a formal agreement with the relevant team in the police that reports can be made to them directly, then reports may be made this way. In all cases you should ensure that you are given a reference number for the case and that you keep a record of it.

2.3a Making a report

It is recommended that you make a report orally by **calling 101**, the single non-emergency number.

When you call 101, the system will determine your location and connect you to the police force covering that area. You will hear a recorded message announcing the police force you are being connected to. You will then be given a choice of which force to be connected to – if you are calling with a report relating to an area outside the force area which you are calling from, you can ask to be directed to that force.

[6] As required by section 5B (5)(c) of the 2003 Act (as amended by the Serious Crime Act 2015)

Calls to 101 are answered by trained police officers and staff in the control room of the local police force. The call handler will log the call and refer it to the relevant team within the force, who will call you back to ask for additional information and discuss the case in more detail.

You should be prepared to provide the call handler with the following information:

- explain that you are making a report under the FGM mandatory reporting duty
- your details:
    - name
    - contact details (work telephone number and e-mail address) and times when you will be available to be called back
    - role
    - place of work
- details of your organisation's designated safeguarding lead:
    - name
    - contact details (work telephone number and e-mail address)
    - place of work
- the girl's details:
    - name
    - age/date of birth
    - address
- if applicable, confirm that you have undertaken, or will undertake, safeguarding actions, as required by the Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate.

You will be given a reference number for the call and should ensure that you document this in your records (see section 2.3b).

2.3b Record keeping

Throughout the process, you should ensure that you keep a comprehensive record of any discussions held and subsequent decisions made, in line with standard safeguarding practice. This will include the circumstances surrounding the initial identification or disclosure of FGM, details of any safeguarding actions which were taken, and when and how you reported the case to the police (including the case reference number). You should also ensure that your organisation's designated safeguarding lead is kept updated as appropriate.

2.3c Informing the child's family

In line with safeguarding best practice, you should contact the girl and/or her parents or guardians as appropriate to explain the report, why it is being made, and what it means. Wherever possible, you should have this discussion in advance of/in parallel to the report being made. Advice and support on how to talk to girls and parents/guardians about FGM is available in the multi-agency statutory guidance on FGM.

However, if you believe that telling the child/parents about the report may result in a risk of serious harm to the child or anyone else, or of the family fleeing the country, you should not discuss it. For more information, please see information sharing advice for safeguarding practitioners. If you are unsure or have concerns, you should discuss these with your designated safeguarding lead.

2.4 Your responsibilities after you have made a report

In relation to any next steps, you should continue to have regard to your wider safeguarding and professional responsibilities, including any relevant standards issued by your regulatory body. For example, in a health context, your responsibilities include responding to the physical and psychological needs of the girl.

Depending on your role and the specific circumstances of the case, you may be required to contribute to the multi-agency response or other follow up to the case which will follow your report (see Section 3). If you are unsure, you should seek advice from your designated safeguarding lead.

2.5 Safeguarding duty in Wales

Professionals working within Wales should be aware that section 130 of the Social Services and Well-being (Wales) Act 2014 also applies to cases covered by the FGM mandatory reporting duty. The all-Wales child protection procedures, adopted by all safeguarding boards in Wales, provide a consistent framework for referral, consideration, and determining action by all safeguarding partners in Wales, including a dedicated protocol on FGM.

Section 130 came into force in April 2016. It requires "relevant partners"[7] of the local authority to inform the local authority where they have reasonable cause to suspect that a child within the local authority's area is a child at risk (i.e. is experiencing or is at risk of abuse, neglect or other kinds of harm, and has needs for care and support). To comply with both duties, professionals in Wales who identify cases falling within the FGM mandatory reporting duty need to make a report to both the police and the local authority.

[7] Section 162(4) of the Social Services and Well-being (Wales) Act 2014 defines relevant partners as follows:
"(a) the local policing body and the chief officer of police for a police area any part of which falls within the area of the local authority;
(b) any other local authority with which the authority agrees that it would be appropriate to co-operate under this section;
(c) the Secretary of State to the extent that the Secretary of State is discharging functions under sections 2 and 3 of the Offender Management Act 2007 in relation to Wales;
(d) any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 to act as a relevant partner of the authority;
(e) a Local Health Board for an area any part of which falls within the area of the authority;
(f) an NHS trust providing services in the area of the authority;
(g) the Welsh Ministers to the extent that they are discharging functions under Part 2 of the Learning and Skills Act 2000;
(h) such a person, or a person of such description, as regulations may specify."

3. Next steps following a report

Upon receipt of a report, the police will record the information and initiate the multi-agency response, in line with local safeguarding arrangements. Exact procedures will vary across local areas. If the police consider that emergency action is needed to protect the child, they may take action in advance of the multi-agency response.

While the multi-agency response will be initiated by the police, as they are the agency receiving the report, they will consult children's social care prior to taking action.

Factors considered may include:

- measures necessary to protect the girl/others identified as being at risk of harm (children's social care lead);
- possible criminal investigation (police lead); and
- the health and wellbeing requirements of the girl/others, including how the care will be delivered (health lead).

The protection of the child must be paramount at all times. The multi-agency response should consider any wider health or emotional support that the child may need. In considering the case and next steps, local safeguarding processes should continue to be followed, in line with wider relevant guidance, including: Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate, the multi-agency statutory guidance on FGM, information sharing, and, for the police, the authorised professional practice on FGM.

The police will provide you with feedback on the outcome of the case, including an update on any safeguarding action taken.

3.1 FGM Protection Orders

Depending on the circumstances of the case, the police or local authority may wish to consider applying for an FGM Protection Order (FGMPO) either to protect the girl or to protect other girls who may be at risk (e.g. siblings). An FGMPO is a civil order which may be made for the purposes of protecting a girl at risk of FGM or protecting a girl against whom an FGM offence has been committed.

4. Failure to comply with the duty

Cases of failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession. **FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.**

4.1 Health and social care professionals

For health and social care professionals, failure to comply with the duty may be considered through fitness to practise proceedings by the regulator with whom the professional is registered.

Regulators will use their frameworks to consider a professional's ability currently to practise safely. This will therefore take all aspects of the circumstances of the case into consideration, including the safety of the individual child and her immediate needs. This may result in a wide variety of recommendations as to suitable action (e.g. re-training or supervision). Regulators may wish to issue guidance to their registrants as to how to act and when action may be taken.

4.2 Teachers

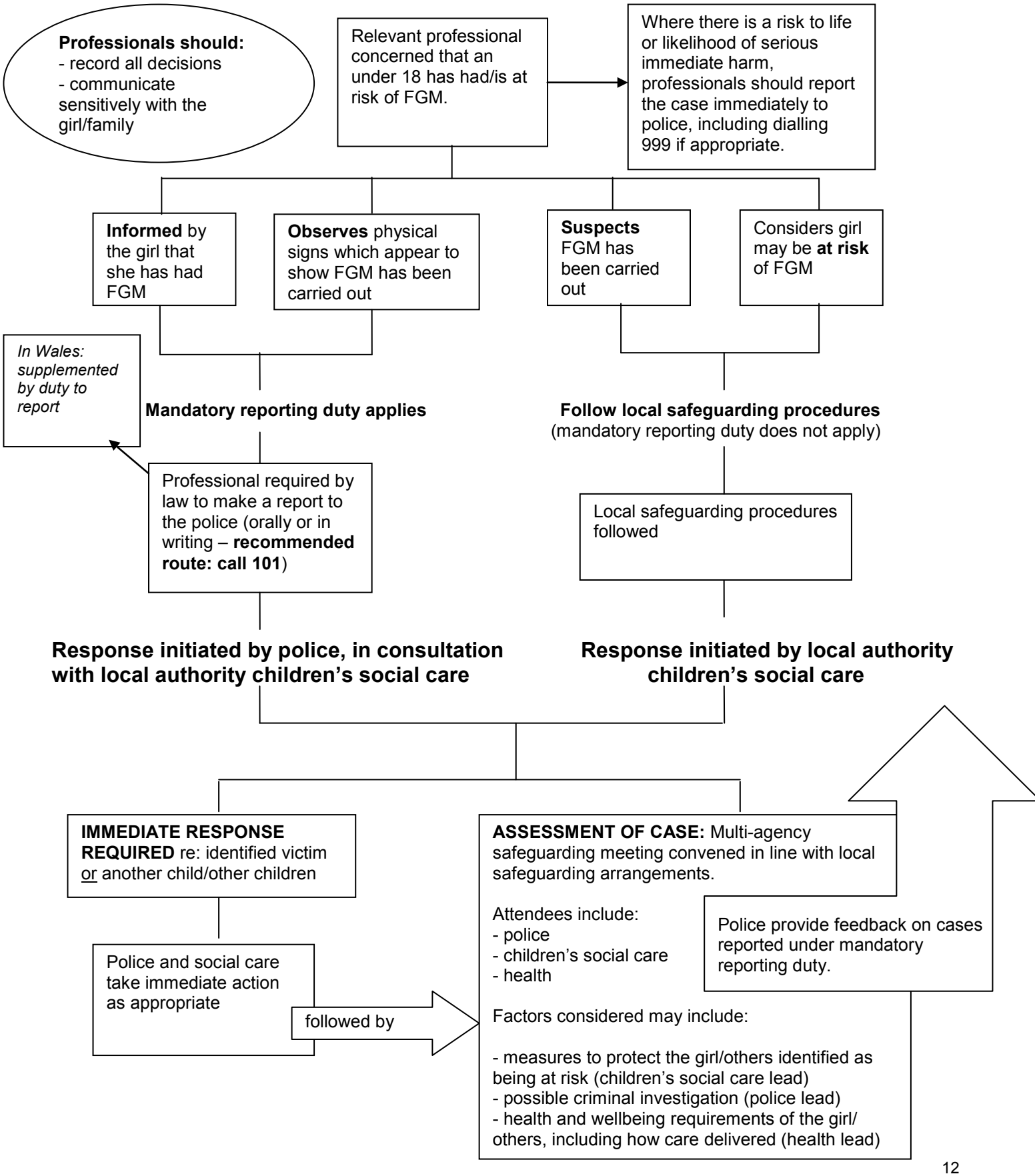
For teachers, schools will need to consider any failure to comply with the duty in accordance with their staff disciplinary procedures. Where the school determines it is appropriate to dismiss the teacher as a result of the failure to comply, or the teacher would have been dismissed had they not resigned, the school must consider whether to refer the matter to the National College of Teaching and Leadership (NCTL) in England or the Education Workforce Council (EWC) in Wales, as regulators of the teaching profession.

For teachers in England, the NCTL will consider referrals to determine whether the facts presented in respect of the individual's failure to comply with the duty are proven and whether they amount to unacceptable professional conduct or conduct likely to bring the profession into disrepute. If proven, the NCTL will consider whether it is appropriate to make a prohibition order which prevents the individual from carrying out teaching work in any school, children's home, sixth form college, and relevant youth accommodation in England.

For teachers in Wales, in considering cases the EWC will look at the individual's conduct and consider whether their failure to comply with the duty was so serious that it should affect their registration, which may include initiating fitness to practise proceedings.

Annex A – FGM mandatory reporting process map

This process map is intended to demonstrate where the FGM mandatory reporting duty fits within existing processes. It is not intended to be an exhaustive guide, and should be considered in the context of wider safeguarding guidance and processes.



Annex B – Q and A

Who the duty applies to

How do I know if the duty applies to me?

The duty applies to all regulated health and social care professionals and teachers in England and Wales. This covers:

- Health and social care professionals registered with any of the regulatory bodies within the remit of the Professional Standards Authority for Health and Social Care, with the exception of the Pharmaceutical Society of Northern Ireland (full list at section one);

- Teachers in England and Wales. This includes qualified teachers or persons who are employed or engaged to carry out teaching work in schools and other institutions, and, in Wales, education practitioners regulated by the Education Workforce Council; and

- Social care workers in Wales (i.e. those registered with the Care Council for Wales)[8].

If you are still unsure whether the duty applies to you, check with your designated safeguarding lead.

Does the duty apply to professionals working in private education/healthcare?

The duty applies to all regulated health and social care professionals and teachers in England and Wales, including those working in private education and healthcare.

Where regulated professionals/teachers working in private education or healthcare identify a case of FGM which falls within the mandatory reporting duty, they are required to make a report to the police, provided the case was discovered in the course of their professional duties.

I am a relevant professional working in Scotland/Northern Ireland – do I have to comply with this duty?

No. The FGM mandatory reporting duty applies in England and Wales only. If you are a teacher or regulated health or social care professional working in Scotland or Northern Ireland, the duty does not apply – you should continue to comply with your existing safeguarding responsibilities.

[8] S5B(11) of the Female Genital Mutilation Act 2003 defines a "social care worker" as a person registered in a register maintained by the Care Council for Wales under section 56 of the Care Standards Act 2000.

Education professionals

Which teachers are within scope of the duty?

In England, the scope of the duty is in line with the regulatory coverage of the National College for Teaching and Leadership (NCTL).

The duty applies to any teacher who is employed or engaged to carry out 'teaching work', whether or not they have qualified teacher status, in maintained schools, academies, free schools, independent schools, non-maintained special schools, sixth form colleges, 16-19 academies, relevant youth accommodation or children's homes in England.

'Teaching work' is defined as being each of the following activities: planning and preparing lessons and courses for pupils; delivering lessons to pupils; assessing and/or reporting on the development, progress and attainment of pupils.

The above would include a teacher carrying out one or more of the above activities as part of their Qualified Teacher Status induction period - this would include those in their second year of Teach First, but not trainee teachers in other circumstances, nor teaching/classroom assistants.

In Wales, the scope of the duty is in line with the regulatory coverage of the Education Workforce Council (EWC), which regulates education practitioners in Wales. This covers: teachers in maintained schools, Further Education (FE) teachers, and learning support staff in both school and FE settings.

I am employed as a teacher but do not have Qualified Teacher Status. Does the duty apply to me?

Yes. The duty applies to anyone employed or engaged to carry out teaching work in specified settings, whether or not they have Qualified Teacher Status (see question above for details of the relevant settings).

I work as a teacher in a Further Education (FE) college. Does the duty apply to me?

In Wales, the duty applies to teachers and learning support staff in FE colleges.

If you are a teacher in a FE college in England, the duty does not apply. You should, however, follow local safeguarding procedures when you know or have reason to suspect that a girl has undergone FGM, or is at risk of FGM.

When the duty applies

I have identified a girl under 18 who I suspect may have undergone FGM, does the duty apply?

The duty does not apply in relation to suspected cases - it is limited to 'known' cases (i.e. those which are visually identified or disclosed to a professional by the victim – see section 2.1 for more information). In these cases, you should follow local safeguarding procedures. If you are concerned that there is an immediate threat you should take immediate action in line with local safeguarding procedures.

For more information, please see Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate, and the multi-agency statutory guidance on FGM.

I have identified a girl under 18 who I think may be at risk of FGM, does the duty apply?

The duty does not apply in relation to at risk cases - it is limited to 'known' cases (i.e. those which are visually identified or disclosed to a professional by the victim – see section 2.1 for more information). If you are concerned that a girl may be at risk of FGM, you should follow local safeguarding procedures.

Where there is a risk to life or likelihood of serious immediate harm, professionals should report the case immediately to police, including dialling 999 if appropriate.

For more information, on handling at risk cases, please see Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate, and the multi-agency statutory guidance on FGM.

I don't know much about FGM, what should I do to make sure I comply with the duty?

A range of information and guidance on FGM is available for all professionals, including a free FGM e-learning package.

For healthcare professionals, Health Education England provide a free 10-15 minute FGM introductory session which gives an overview of what FGM is and the issues related to it.

In Wales, each health board has an FGM Lead and any queries should be referred to them. The Welsh Government's National Training Framework on violence against women, domestic violence and sexual abuse will introduce a standard of training for these issues, related to job role, across the Welsh public service. The National Training Framework includes both basic, and fundamental levels of training and a specialist subject syllabus, each of which will include FGM.

Detailed guidance on FGM for professionals and organisations is available in the multi-agency statutory guidance on FGM.

Do I only have to make a report if I am 100% certain that FGM has been carried out?

No. The duty is limited to 'known' cases (i.e. those which are visually identified or disclosed to a professional by the victim – see section 2.1 for more information), but this does not mean that you must be 100% certain that FGM has been carried out or that a clinical diagnosis must have taken place prior to a report being made.

You are not required to 'verify' that FGM has occurred in order for the duty to apply and a report to be made. Whether the girl needs to be referred for a diagnosis will be considered as part of the subsequent multi-agency response.

The duty applies to my profession and I do volunteer work with children. When volunteering, a girl has disclosed that she has had FGM. Am I required to report under the duty?

The duty only applies to cases discovered by a relevant professional in the course of the professional work. It therefore does not apply to cases a relevant professional discovers outside of their professional work, and this includes volunteer work.

If you discover a case in your capacity as a volunteer, you should ensure that you follow appropriate safeguarding procedures (in line with the organisation's processes) and any wider safeguarding responsibilities which apply to your profession.

I have identified a case but the victim is over 18, what should I do?

The duty does not apply in cases where the woman is over 18 at the time of the disclosure/discovery of FGM (even if she was under 18 when the FGM was carried out).

Whatever an individual's circumstances, they have rights which should always be respected, such as the right to personal safety and to be given accurate information about their rights and choices. Professionals should listen to the victim and respect their wishes whenever possible. However, there may be times when a victim wants to take a course of action that may put them at risk – in these circumstances, professionals should explain the potential outcomes and risks to the victim and take the necessary adult protection precautions, including signposting her to health services which will be able to consider any additional support needed.

Professionals should also be clear that FGM is a criminal offence in the UK and must not be permitted or condoned. They should consider whether there are others in the family who may be at risk.

Further guidance on handling adult cases is available in the multi-agency statutory guidance on FGM.

I have become aware that FGM has been carried out on a girl under 18, but I know that another person in my profession has already referred this case to the police. Am I required to make another report to the police?

If you are aware that a report to the police in connection with the same act of FGM has already been made by someone from your profession, the duty does not apply (i.e. you are not required to make a second report)[9]. If, however, you are unsure, or if the person making the report does not belong to a profession captured by the duty, you should report the case to the police, and highlight that a report may have been made previously.

A parent has told me their daughter has had FGM, but I cannot ask the girl as I do not have contact or a relationship with her. What do I do?

If a parent, guardian, sibling or other individual discloses that a girl under 18 has had FGM, you should follow local safeguarding procedures, which may include a referral to children's social services. In some circumstances this will also involve informing the police.

For further information, including advice and support about how to talk to girls and parents/guardians about FGM, see the multi-agency statutory guidance on FGM.

[9] For these purposes, professionals regulated by a body which belongs to the Professional Standards Authority for Health and Social Care are considered as belonging to the same profession.

I have identified a girl under 18 who has had a genital piercing/genital tattoo/female genital cosmetic surgery. What should I do?

You should make a report. Further information on genital piercings and female genital cosmetic surgery and the law in England and Wales is available in the multi-agency statutory guidance on FGM. For the purpose of the duty, you are not required to be satisfied that a criminal offence has been committed.

Visually identified cases

I don't know what FGM looks like – what should I do if I think I have seen it?

The duty is limited to 'known' cases (i.e. those which are visually identified or disclosed to a professional by the victim), but this does not mean that you must be 100% certain that FGM has been carried out or that a clinical diagnosis must have taken place prior to a report being made.

If, in the course of your work, you see physical signs which you think appear to show that a girl under 18 has had FGM, this is the point at which the duty applies and at which you are required to make a report. The duty does not require there to be a full clinical diagnosis confirming FGM before a report is made, and one should not be carried out unless you identified the case as part of an examination already under way and are able to ascertain this as part of that.

I am a clinician and I am concerned as I know that some types of FGM (e.g. type 4) are very difficult to notice unless you are undertaking an examination with the specific purpose of looking for the signs. What if I have carried out a procedure on a patient (e.g. inserting a catheter) and at a later date that patient is identified as having had FGM?

If an allegation of failure to report is made, in considering whether a person has genuinely failed to notice the signs of FGM, all of the relevant circumstances will be taken into account by the regulators, including your experience and what could reasonably have been expected. All relevant information will be taken into account, including the fact that experts in the field can find it difficult to see indications of FGM having taken place in some circumstances.

Making reports

How do I make a report?

Information on making reports is outlined in section 2.3.

I am concerned that if I inform the family before making the report the family may disappear or coerce the girl into changing her account, what should I do?

Please see section 2.3c. If you are still unsure or have concerns, you should discuss these with your designated safeguarding lead.

Do I have to inform the girl's family before making a report?

In line with safeguarding best practice, you should explain the report, why it is being made, and what it means with the girl and/or her parents or guardians as appropriate. See section 2.3c for more information.

I have made a report under the duty, but my local process is to make a full referral to social services. Why do I have to report twice?

The legislation requires you to make a report to the police and does not require a second report to social services. Local areas may wish to update their procedures to reflect that a report made under the mandatory reporting duty is sufficient and duplicate reporting is not required, but that is a matter for local decision.

Professionals working within Wales should be aware that section 130 of the Social Services and Well-being (Wales) Act 2014 also applies to cases covered by the FGM mandatory reporting duty.

I have concerns about making a report via 101 – is this process secure?

Yes. Calls to 101 are answered by trained police officers and staff in the control room of the local police force. Police forces have responsibilities regarding the management of information, including a statutory responsibility to comply with the Data Protection Act 1998.

I am an expert practitioner in this field and we already have reporting processes directly to the police, through local arrangements with the specialist unit in the force who deal with these cases. Do I have to call 101?

No. The legislation requires a report to be made to the police, but it does not mandate the process for making the report. If you have a formal agreement with the relevant team in the police that reports can be made to them directly, then reports may be made this way. In all cases you should ensure that you are given a reference number for the case and keep a record of this.

The 101 process is recommended as a simple and clear reporting route for professionals who need to make a report under the duty and who do not routinely have contact with the relevant team within the police.

I have a duty of confidence to my patients, doesn't requiring a report to the police breach this?

No. Complying with the duty does not breach any confidentiality requirement or other restriction on disclosure which might otherwise apply, including any legal requirements. If you are a relevant professional and you become aware of a case where the duty applies, the legislation requires you to make a report to the police.

I work in a clinic where patients do not have to provide their personal details. I have identified a case where the duty applies, but I suspect that the details I have for the girl are not accurate. What should I do?

If you would not previously have taken any additional action to obtain accurate details, that should not change. You should make the report according to the available information and let the police know that you are not sure whether all of the information that you have is accurate.

I have identified a case where the duty applies, and it is not clear from the girl's records whether a report has already been made - what should I do?

If the girl's records are unclear, you should report the case to the police in accordance with the duty and highlight that you believe a report may have been made previously.

What should I do if I have come under the duty to report and I think another professional working in my organisation should have made a report previously, but I cannot see any evidence that they ever did anything?

You should report the case to the police in accordance with the duty and highlight that you believe a report may have been made previously. As failure to comply with the duty represents a failure of the individual to comply with their professional duties, you may also wish to consider whether to highlight this to the relevant safeguarding lead in your organisation.

What should I do if the girl's family assure me that the case has been reported to the police under the duty, but I cannot see any evidence of this?

If there is no evidence to support this, or if the report was made by a professional belonging to a different profession, you should report the case to the police, and highlight that the family have indicated a report may have been made previously.

You can reassure the family that if a report has already been made and an appropriate response put in place, then this will be identified by the police early on in the process.

I know about the duty, and as a result, I want to avoid discussing FGM in the course of my work so that I don't have to deal with what is said. Is that ok?

No. All professionals subject to this duty have wider professional and safeguarding responsibilities. If a professional deliberately avoids this issue and alters the care or support which they would otherwise give to the girl, this would conflict with their wider responsibilities and follow up action may be taken.

Cases identified before 31 October 2015

I became aware before the duty came into effect (31 October 2015) that a girl under 18 had FGM carried out, am I required to report this?

The mandatory reporting duty applies from 31 October 2015 onwards, and therefore does not apply to cases discovered before this.

However, as a crime may have been committed, if you have concerns about a case prior to this date, you should consult your designated safeguarding lead to consider whether a report to the police may be appropriate.

After making the report

I made a report - will I be informed of the outcome and of any safeguarding action being taken?

The police will provide you with feedback on the outcome of the case and about any follow-up action being taken. See section 3 for more information.

What if the investigation identifies that there are no physical signs of the abuse, but the child gives an account of having undergone FGM?

If a girl under 18 tells you, as part of a conversation you have initiated or otherwise, that she has had FGM, then you should treat this as a disclosure and make a report under the duty and take appropriate action in line with your local safeguarding processes.

If you make a report as a result of such a disclosure and there is later found to be no physical evidence of FGM, you will not be penalised for making the report.

The girl's family are scared and worried about the follow-up. What can I do to help reassure them and explain what they can expect?

For further information, including advice and support about how to talk to girls and parents/guardians about FGM, see the multi-agency statutory guidance on FGM. You may also wish to seek advice from your manager or designated safeguarding lead.

A fact sheet for communities which explains the duty, including what happens after a case is reported to the police, is available in 11 languages.

What if there is a breakdown in trust as a result of my having made a report to the police?

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). If the duty applies to you and you identify a relevant case, you are legally required to make a report to the police.

There may be situations where this is difficult, but you are advised to be open and honest, in line with best practice on information sharing and safeguarding.

For further information, including advice and support about how to talk to girls and parents/guardians about FGM, see the multi-agency guidance on FGM. You may also wish to seek advice from your manager or designated safeguarding lead.

What if I am organising the multi-agency response, but I cannot get involvement or engagement from one of the other sectors?

Your response should be in line with wider safeguarding procedures – for more information, please see Working Together to Safeguard Children (in England) or Working Together to Safeguard People (in Wales) as appropriate.

CITY OF WOLVERHAMPTON COUNCIL

REFERRAL OF AN ALLEGATION AGAINST AN ADULT WHO WORKS WITH ADULTS WITH CARE AND SUPPORT NEEDS

TO BE COMPLETED WITHIN 24 HOURS OF BECOMING AWARE OF THE CONCERN

A Person in a Position of Trust is anyone who carries out work, be that paid or unpaid, on behalf of an agency which has access to children or adults with care and support needs or has access to privileged information about children or adults with care and support needs as part of their work.

The criteria :-

A person who works with adults with care and support needs in a position of trust, whether an employee, volunteer or student (paid and unpaid) and

Where those concerns or allegations indicate that a person in a position of trust poses a risk of harm to adults with care and support needs. These concerns or allegations could include, for example that the person in a position of trust has**:**

- **behaved in a way that has harmed, or may have harmed, a child and/or adult with care and support needs**
- **possibly committed a criminal offence against children, or related to a child, or and/or adult with care and support needs**
- **behaved towards a child/children/ and/or adult with care and support needs in a way that indicates s/he may pose a risk to children/adult with care and support needs .**
- **behaved or may have behaved in a way that indicates they may not be suitable to work with children and/or adult with care and support needs**

When making a referral ***you must make a clear distinction between an allegation, a concern about the quality of care or practice or a complaint*** - this is helpful as we just want the allegations that highlight those incidents where there is a risk of harm.

Allegations against people who work with adults at risk must not be dealt with in isolation. Any corresponding action necessary to address the welfare of adults with care and support needs should be taken without delay and in a coordinated manner, to prevent the need for further safeguarding in future**.**

Adult at risk definition

'an adult at risk.' An adult at risk of abuse or neglect is defined as someone who has needs for care and support, who is experiencing, or at risk of, abuse or neglect and as a result of their care needs - is unable to protect themselves. All partners should be using this definition when raising a concern about abuse/neglect of an adult.

Six key principles underpin all adult safeguarding work

Empowerment

People being supported and encouraged to make their own decisions and informed consent.

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Prevention

It is better to take action before harm occurs.

Accountability

Accountability and transparency in delivering safeguarding.

Proportionality

The least intrusive response appropriate to the risk presented.

Protection

Support and representation for those in greatest need.

Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Decisions on sharing information ***must be justifiable and proportionate, based on the potential or actual harm to adults or children at risk and the rationale for decision-making should always be recorded.***

If a local authority is given information about such concerns they should give careful consideration to what information should be shared with employers (or student body or voluntary organisation) to enable risk assessment.

When sharing information about adults, children and young people at risk between agencies it should only be shared:

- where relevant and necessary, not simply all the information held
- with the relevant people who need all or some of the information
- when there is a specific need for the information to be shared at that time

Allegations against people who work with adults at risk must not be dealt with in isolation. Any corresponding action necessary to address the welfare of adults with care and support needs should be taken without delay and in a coordinated manner, to prevent the need for further safeguarding in future.

Is the person aware of the referral?
If not, why?
What are their views about this being shared with their employer?

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Title	Miss/Mr/Mrs/Ms	First Name	
Middle Name		Surname	
Date of Birth		Ethnicity	
Home Address			
Current Job role and brief description of responsibilities			
Employing Agency			
Length of Service			
Previous Employment & Job Roles			
Have allegations been made against this individual previously?	☐Yes ☐No ☐Not known		
If Yes – please specify here			

Details of adult with care and support needs – to whom the allegation relates

	Adult at risk	Adult at risk	Adult at risk
Name			
Date of Birth			
Ethnicity			
Eclipse Care first PER number			
Home Address			
Care home address (if applicable)			
Relationship to Adult			

Details of other child(ren) and/or adults with care and support needs who live in the same household as Person in Position of Trust

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	Child	Child/Adult 2	Child/Adult 3*
Name			
Date of Birth			
Ethnicity			
Eclipse PER number			
Home Address			
Care home address (if applicable)			
Relationship to Adult			

**(If there are more than 3 children/adults – please add details below)

Details of the allegation

Please explain how the referral meets the criteria and the key principles as identified above?		
Date of Alleged Incident		
Date of when the referrer became aware of the incident		
Date of Referral made to LADO		
Details of Referrer	Name	
	Job Title	

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Contacts Details - Mobile number Email address	
Has this allegation been referred through MASH	☐Yes ☐No ☐n/a

Description of allegation/details of concerns
(Please provide full names of any person referenced within this referral, not initials)

Any other known positions of trust held?
(Please include paid and voluntary roles)
☐Yes ☐No ☐n/a

Other agencies involved and contact details
☐Yes ☐No ☐n/a

Action taken by Organisation/Employer to date:

Which section of the criteria does the concerns fall under and why?

Thank you for completing the form, please email your completed form to LADO@wolverhampton.gov.uk / 01902 550661

Wolverhampton
A Safe City
Operating as Wolverhampton's Local Police & Crime Board

Working together to keep you safe from abuse and neglect, and promote your well-being

Wolverhampton Domestic Violence Forum
Working in partnership to tackle domestic violence

Wolverhampton Over-Arching

Domestic Violence & Abuse Protocol and Guidance

Updated and Approved by SWP April 2018

Contents **Page**

1. The Purpose of this Protocol

The aim of this protocol is to contribute to reducing the risk of serious harm and death through earlier identification and intervention in the lives of families affected by domestic violence and abuse.

Front-line organisations can provide a critical path for victims to disclose violence and abuse. Trained practitioners should ask routine and specific questions around domestic violence and abuse, undertake a risk assessment, and signpost victims and perpetrators to appropriate specialist services, empowering individuals to make informed decisions, and preventing repeat victimisation and escalation of violence.

Every organisation should have its own policy and practice documents relating to domestic violence, and this protocol should be read in conjunction with individual agencies' own documents. If you would like support with your organisation's domestic violence policy, contact Wolverhampton Domestic Violence Forum on Kathy.Cole-Evans@wolverhampton.gov.uk .

2. Domestic Violence and Abuse Definition

In March 2013, the Government extended the domestic violence and abuse definition to include coercive and controlling behaviour, and to incorporate young people aged 16-17 years.

The **domestic violence definition** includes:

'**Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.'**

This can encompass, but is not limited to the following types of abuse: **psychological, physical, sexual, financial, and 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 and intimidation 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.

3. National and Local Context

The Home Office estimates that each year in England and Wales there are nearly 2 million people suffering domestic violence and abuse, 1.3 million of these are female victims. Of these more than 100,000 mostly women are assessed at high and imminent risk of serious

harm or murder, with 130,000 children living in high risk homes. These crimes are often hidden away behind closed doors, with victims suffering in silence. Fewer than 1 in 4 people who suffer violence and abuse at the hands of their partner, and only around 1 in 10 women who experience serious sexual assault report it to the police. Domestic violence and abuse is not a one off-occurrence and left unchecked, it is known to escalate in frequency and severity over time.

A snapshot in Wolverhampton in 2016/17 informs us that there were:

- 6,000 domestic violence and abuse incidents reported to West Midlands Police
- 652 cases assessed at high and imminent risk of serious harm or murder (35% of these being repeat referrals, with 937 associated children)

In 2011 The Domestic Violence, Crime & Victims Act 2004 imposed a statutory duty on community safety partnerships to conduct a domestic homicide review when a domestic homicide occurs. The purpose of domestic homicide reviews is to identify lessons to be learned that could prevent a future domestic homicide in similar circumstances. In England and Wales, domestic violence results in two homicides a week on average; there were 113 women killed by a current or previous intimate partner in 2016. There have been 4 full domestic homicide reviews completed in Wolverhampton since 2011.

Common themes emerging from domestic homicide reviews, are similar to those arising from serious case reviews for children and vulnerable adults. These include lack of appropriate information sharing, lack of appropriate translation and interpretation services, mental health and mental capacity issues, long-terms carers, and key front-line professionals missing opportunities to identify domestic violence and abuse and put in place appropriate interventions.

4. Victims of Domestic Violence

The latest national statistics show that prevalence of domestic violence and abuse is increasing among young women under 24 years, and those who have a long-term illness or disability. However, victims of domestic violence and abuse do not fit a particular profile. They include work colleagues, family members, service users, neighbours, etc. Victims may not feel able to tell professionals that they are subject to domestic violence and abuse, but many victims want professionals to ask questions about domestic violence and abuse in order that they can disclose this information, and be assisted to seek help. Domestic violence is a high volume, highly complex, high cost crime that transcends all normal gender, socio-economic, age, cultural, religious, and other boundaries. It can affect anyone however key features are summarised below:

- The majority of domestic violence and abuse victims are female, and the majority of perpetrators are male. There are female perpetrators and male victims, and that domestic violence and abuse occurs in heterosexual and single sex relationships.
- Approximately 88% of domestic violence reported to the police involves female victims of male perpetrators, with approximately 12% being male victims.
- Women are more likely than men to be the victim of repeated and multiple incidents.

- Women are five times more likely to be seriously hurt or murdered at the point of leaving an abusive relationship.
- Women are more likely to suffer different types of domestic abuse, eg partner or family abuse, sexual assault, stalking, post-separation abuse, and in particular sexual violence.
- On average women are assaulted 35 times by a partner or ex-partner before seeking help from agencies. Violence and abuse are not reported for many reasons including:
    - acceptance of abuse as normal; not recognising that they are being abused,
    - embarrassment or shame; not wanting to air dirty linen in public,
    - fear of their future (& that of their children), where and how they'll live and eat,
    - fear of retaliation.
- Older women and those with disabilities, reliant on family members and carers are twice as likely to suffer domestic violence
- Barriers to disclosing domestic violence/abuse exist for victims in same sex relationships as their sexuality may not have been shared with family or friends.
- Ethnic minority communities may also face additional perceived and real cultural barriers to reporting violence and abuse, sometimes for fear of so-called honour based violence and/or being rejected by their families and communities.
- Perpetrators of domestic violence and abuse sometimes make counter-allegations of violence and abuse against their victims.
- Criminal justice system responds to reported single events rather than to the longer term coercive and controlling behaviour that constitutes domestic violence that may have resulted in this single act of retaliation.

5. Children as Victims of Domestic Violence

The legal definition of 'significant harm' to children to include harm caused by witnessing or overhearing abuse of another, especially in a context of domestic violence, was extended under the Adoption and Children Act 2002. This added to the legal framework for child protection set out in the Children Act 1989 and 2004, the key principle of which was that the welfare of the child is the paramount consideration. Section 17 makes provision for local authorities to provide support and care, and for services to safeguard and promote the welfare and development of the child, and to support mothers and their children even where the mother has no recourse to public funds.

The majority of children in households where there is domestic violence witness that violence and abuse, mostly in the same or next room. This includes getting caught in the middle of an incident, being used as a shield to prevent further violence, hearing the abuse from the next room, seeing a parent's physical injuries following violence, having to stay in one room, being prevented from playing, being forced to witness sexual abuse, or forced to take part in verbally abusing the victim. All children witnessing domestic violence are being emotionally abused.

The effects of domestic violence on children are various, and include short and long term cognitive, behavioural, and emotional effects. Responses vary according to a multitude of factors including age, race, sex and stage of development. It is equally important to remember that these responses may also be caused by something other than witnessing domestic violence, and therefore a thorough assessment of a child's situation is vital.

In England and Wales, it is estimated that there are more than 750,000 children per year witnessing and/or experiencing domestic violence and abuse, and nearly three quarters of the

children on Child Protection Plans live in households where domestic violence is a significant feature. Serious case reviews consistently demonstrate that domestic violence was a significant feature of family life.

Research demonstrates that there is a cross-over between 66% and 90% of domestic violence with child abuse in families. It is therefore critical that where there are children and/or pregnant women in a household where domestic violence and abuse is a feature, that the effect on the children should be assessed.

6. Domestic Violence and Abuse and The Care Act 2014

The Care Act 2014 introduced a consolidated approach to Adult Social Care that specified new duties on Local Authorities and partners, outlined new rights for Service Users and Carers, and made Adult Safeguarding Boards statutory. Local Authorities are given a remit of their populations' broader care needs, specifying duties to undertake preventative work to prevent, reduce, and delay the need for care and support.

The Care Act recognises that a significant proportion of people needing safeguarding support do so because they are experiencing domestic abuse, which is specifically highlighted as one of the types of abuse for which such protection and prevention is required, whether the abuse or neglect is deliberate or unintentional.

It specifies that individual wellbeing is concerned with freedom from domestic violence and other forms of control and exploitation, and that domestic abuse service providers should be formally involved in providing a range of services from prevention (e.g. outreach and educational campaigns) to acute interventions for vulnerable adults, such as those provided by IDVA services.

National statistics demonstrate that more than 50% of UK disabled women experience domestic violence and rape, which is double the rate of non-disabled women. Domestic violence is known to be a longer-term pattern of coercive and controlling behaviour that escalates in severity and frequency over time. Domestic homicide review analysis reveals a disproportionate number of cases with both victims and/or perpetrators in a carer capacity, where the person with care and support needs is more reliant on the individual providing their care, are less able to access external support and escape the abuse.

5. Multi-Agency Safeguarding Hub

Wolverhampton has in place a Multi-Agency Safeguarding Hub (MASH) as a multi-agency co-located team to assess all safeguarding concerns relating to children and adults, the first Local Authority area in the West Midlands to do so. Arrangements include both co-located and some 'virtual' partners.

Domestic violence and abuse cases where there are children and/or pregnant women referred by West Midlands Police are pre-screened by the MASH to identify those meeting thresholds for immediate child protection and child in need arrangements. Those cases below this threshold are screened and assessed using the Barnardo's Joint Screening Tool alongside MASH by a multi-agency team. Wolverhampton's Barnardo's Joint Screening Tool Protocol can be found at www.wolverhamptonsafeguarding.org.uk

The MARAC Coordinator, responsible for coordinating partnership arrangements and plans to reduce risks to DV victims at high risk of serious harm/homicide is co-located within the MASH. This facilitates the sharing of relevant child and vulnerable adult information between MARAC and MASH.

To access more detailed information about Wolverhampton's MASH arrangements, please refer to www.wolverhamptonsafeguarding.org.uk

6. Perpetrators of Domestic Violence and Abuse

Mirroring the narrative outlined above for victims of domestic violence and abuse, the majority of incidents reported involve male perpetrators on female victims. However, it is also acknowledged that there are male victims and female perpetrators, and domestic violence occurs in heterosexual and same sex relationships.

Domestic violence cuts across the normal gender, socio-economic, age, cultural, religious and other boundaries, and is prevalent across society and communities.

It is important to remember that the responsibility for the abuse and harm lies with the perpetrator.

Project Mirabel research demonstrates that working with male domestic violence perpetrators alongside supporting their female victims and their children results in sustainable behaviour change for all members of the family. Research into Serious Case Reviews consistently highlights that failing to challenge DV perpetrators and/or facilitating their participation in programmes to recognise and modify their behaviours results in no sustainable change, ongoing abuse in that family, and/or serial abusive behaviours in new relationships.

Social Care Plans should include requirements for perpetrators to address their behaviour, instead of placing responsibility on victims to manage perpetrator behaviour and their access to the family.

A risk based stepped model to managing domestic violence perpetrators and offenders spanning a broad range of preventative and restorative work across universal, targeted, and specialist provision is preferable.

DV Perpetrator Programmes (DVPP)

The National Probation Service has traditionally used sentenced programmes at the end of the criminal justice process to get high risk domestic violence offenders to undertake structured work programmes. Until recently, perpetrator programmes have not consistently been available outside of the criminal justice process in the city. Wolverhampton now has two accredited programmes available including a two-year pilot programme for Social Care referrals where child protection and child in need plans are in place, and a separate community based perpetrator programme for self-referrals and referrals through other early help organisations for men with or without children.

Click here to access details of the range of DV perpetrator programmes and perpetrator work that is now available in Wolverhampton.

7. Identification of risk – Domestic Abuse, Stalking, Harassment, & Honour based violence (DASH) Risk Assessment

- The Safe Lives DASH is the national domestic violence risk assessment tool used to determine the level of risk of serious harm or homicide.
- It enables defensible decision making based on the evidence including the risks associated with previous domestic homicides and 'near-misses'.
- It provides a shared understanding of risk in relation to domestic violence, stalking, and so-called honour based violence, in particular for 'high risk of serious harm and homicide" for referral to Multi-Agency Risk Assessment Conferences (MARAC).
- The DASH assessment tool is currently under review by The College of Policing.
- Domestic violence training that includes the Safe Lives DASH risk assessment and referral to MARAC is provided free of charge

The Safe Lives website is a useful resource www.safelives.org.uk

The DASH risk assessment can be found at http://www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

8. Multi-Agency Risk Assessment Conferences (MARAC)

MARAC is a national model of good multi-agency practice in managing and reducing the risks posed to DV victims assessed at high risk of serious and imminent harm or homicide.

- MARAC is a weekly professionals meeting in Wolverhampton.
- The agenda is circulated in advance
- Organisations research their knowledge of the family and identify all risks
- An action plan is agreed to collectively deploy various powers and resources to reduce identified risks.
- Independent DV Advisers (IDVA) undertake crisis intervention and safety planning with high risk victims, and represent victims' up to date information and views at MARAC.
- All MARAC cases are allocated to one of the city's variously deployed IDVAs.

Wolverhampton's MARAC has been identified by Safe Lives as in the top 5 performing MARACs in the country, and commended by OFSTED during the 2016 inspection. Front-line organisations should assess risk using the national DASH risk assessment tool, and refer qualifying high-risk cases to MARAC. Our responsive iterative MARAC monitoring model, recognises and responds to organisations that are not actively referring the expected number of cases.

Successes include a year on year increase in the number of cases being identified and referred to MARAC, and year on year increases of non-Police earlier identification of high risk cases from 4% in 2012 to 39% of our cases in 2017, towards the national target of 40%.

As part of the coordinated community response to domestic violence/abuse, MARAC aims to:

- Share information to increase the safety, health and well-being of victim adults and their children
- Determine whether the perpetrator poses a significant risk to an individual or to the community
- Construct jointly and implement risk management plans with professional support to all those at risk
- Reduce the risk of serious harm
- Reduce repeat victimisation
- Improve agency accountability
- Provide support for staff involved in high-risk domestic violence and abuse cases

MARAC sits alongside but separate from the Multi-Agency Safeguarding Hub (MASH) arrangements for adults and children. This facilitates the proportionate and secure exchange of information at the interface between MARAC and MASH.

Wolverhampton MARAC Protocol 2018 is available at www.wolverhamptonsafeguarding.org.uk

Further information can be found on the Safe Lives website at www.safelives.org.uk

9. Safety planning for victims

Referring a high-risk case to MARAC will result in an Independent DV Adviser (IDVA) being allocated to the victim.

The IDVA will provide crisis intervention, safety planning, coordination of services, and an opportunity for specialist joint working with that individual.

Individuals assessed at standard or medium risk of serious harm, (with consent), can be referred to the single point of contact; current provision is through The Haven Wolverhampton, where victims and survivors will receive safety planning, advice, and support.

Basic safety planning is also incorporated into Wolverhampton DV Forum's training programme to embed as 'business as usual' for front-line staff across organisations. A safety planning leaflet available for victims of domestic violence and abuse is available for front line professionals to assist them in providing basic safety planning advice.

Click here for our Domestic Abuse Safety Planning Leaflet

10. Accessing Appropriate Help, Information and Training

There is a variety of leaflets and resource materials available to provide to victims and perpetrators of domestic violence, all of which are available through Wolverhampton DV Forum (WDVF), and its training programme.

The Safer Wolverhampton Partnership commissions Wolverhampton DV Forum to provide training to partner organisations, which is free of charge. Training can be single or multi-agency, and includes domestic violence, coercive controlling behaviour, forced marriage, honour based violence, female genital mutilation, and rape and sexual violence.

This training satisfies this protocol's building block requirements, including how to ask questions, completing the DASH risk assessment, using care pathways, basic safety planning, learning from domestic homicide reviews, as well as specific training for our Violence Against Women and Girls Champions. WDVF also provides bespoke 'train the trainer' courses for cascading key messages and learning across larger organisations.

To access training and resources, contact 01902 550125, or look on the Safeguarding website www.**wolverhamptonsafeguarding**.org.uk or contact WSCBTraining@wolverhampton.gov.uk

Click here for our contact list of specialist organisations.

Click here for our Support and Advice leaflet

11. Violence Against Women and Girls (VAWG) Champions

A network of VAWG Champions has been developed across Wolverhampton organisations. The role of each VAWG Champion is to increase knowledge and competence of front line staff in their organisation so that they can identify victims of VAWG as early as possible, and ensure safe and effective responses using existing care pathways.

Each Champion will be the lead for VAWG issues within their agency or team, and will:

- Act as a primary point of contact in and out of that unit/agency
- Receive specified training across VAWG subjects
- Receive up to date VAWG information and resources
- Be able to advise colleagues on management of individual cases
- Ensure that local resources and signposting details are kept up to date for their organisation
- Participate in the VAWG Champions quarterly meetings and network
- Be supported by their organisation

12. Community Awareness

In addition to its focus on training, the Violence Against Women and Girls (VAWG) Strategy places equal weight on the need to raise awareness of VAWG issues with our communities to assist individuals to access appropriate help and support, ideally prior to the point of crisis.

Our calendar of events for all strands of VAWG focuses on national and international event dates and campaigns, and year on year builds upon the success of high-profile local publicity campaigns such as 'Orange Wolverhampton', and the West Midlands Police Sentinel Campaign. We are also using NHS England funding that Wolverhampton CCG, Wolverhampton DV Forum, and the Refugee and Migrant Centre has attracted to raise awareness of the illegalities and long-term harms of VAWG with women and men in newly emerging communities. There is also more work planned with school governors and ambassadors, as well as health focused community awareness events.

13. The Coordinated Community Response Model

The UK national model of best practice in dealing effectively with violence against women and girls is that of a coordinated community response model. This places responsibility for responding effectively to domestic violence on individuals as well as on organisations (whether you are a Police Officer, Social Worker, Health Visitor, GP, Judge, Housing Officer, Neighbour, Friend, Colleague, Brother, Aunt, Employer, etc). **This approach requires our communities to advocate that domestic violence is not acceptable and will not be tolerated, that communities are able to report violence and abuse and seek help, and that organisations will follow appropriate procedures to ensure that domestic violence is responded to safely from a victims' and children perspective, as well as for perpetrators.**

14. Organisation Building Blocks for Safe Responses to Domestic Violence and Abuse

To support the coordinated community response model, and respond safely to domestic violence and abuse, organisations will need to have in place a number of basic building blocks.

Expectations on Wolverhampton organisations is that they will:

- Have in place a domestic violence policy for service users
- Have in place a workplace domestic violence policy
- Include a routine question about domestic violence on referral forms/assessments
- Provide spaces for individuals to make safe disclosures
- Hold organisational knowledge about how to avoid unsafe responses
- Ensure that responses are culture and diversity aware
- Train staff in domestic violence to an appropriate level depending on their role, including having a nominated VAWG Champion(s)
- Undertake a DASH risk assessment, or have in place an agreed referral pathway for a DASH risk assessment to be undertaken when domestic violence is disclosed
- Ensure the case is referred to MARAC where the risk assessment identifies the individual as high risk of serious harm or homicide
- Maintain up to date contact details of appropriate local help and information and leaflets to signpost victims to specialist support agencies
- Ensure learning from domestic homicide reviews is embedded
- Where appropriate, ensure that perpetrator programmes incorporate RESPECT standards
- Share domestic violence datasets through partnership arrangements (when requested)
- Ensure these requirements and The West Midlands DV Standards are incorporated into designing, commissioning, and contracting services
- Seek assurance that these requirements and The West Midlands DV Standards are embedded via internal audits
- Provide an annual statement of compliance with these requirements to WDVF Exec Board on request.

15. Legislation and Protective Tools and Powers

There is no criminal offence of ‘domestic violence’, rather there are a number of criminal offences that encompass domestic violence and abuse. There are also various practical protective tools and powers that professionals can deploy as part of a plan to support victims and prevent further harm.

Click here to access the list of criminal offences, policy frameworks, and the most significant protective tools that partners can deploy.

16. Information Sharing and Confidentiality

Domestic homicide reviews, serious case reviews, and safeguarding adult reviews continue to conclude that information sharing is one of the consistent failings in the lead up to serious incidents and deaths. Good information sharing provides a more effective ‘team around the family’ approach. All partners should be committed to sharing proportionate information in a timely way as part of their safeguarding responsibility; if in doubt about sharing information, seek clarity from your line manager.

All organisations will have their own confidentiality protocols that specify that where information disclosed raises safeguarding children or adult concerns, that information must be shared appropriately in order that children and adults can be safeguarded. These protocols must be adhered to.

Wolverhampton has a Tier 1 Over-Arching Information Sharing Protocol (ISP) that provides the framework for how, when, and why information will be shared, underneath which there are tier 2 and 3 subject specific information sharing protocols that outline the purposes of information sharing, eg the Wolverhampton MARAC protocol.

Ending domestic abuse

SafeLives Dash risk checklist
Quick start guidance

You may be looking at this checklist because you are working in a professional capacity with a victim of domestic abuse. These notes are to help you understand the significance of the questions on the checklist. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also be used for lesbian, gay, bisexual relationships and for situations of 'honour'-based violence or family violence. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

The purpose of the Dash risk checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a Marac meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

The Dash risk checklist should be introduced to the victim within the framework of your agency's:

- Confidentiality policy
- Information sharing policy and protocols
- Marac referral policies and protocols

Before you begin to ask the questions in the Dash risk checklist:

- Establish how much time the victim has to talk to you: is it safe to talk now? What are safe contact details?
- Establish the whereabouts of the perpetrator and children
- Explain why you are asking these questions and how it relates to the Marac

While you are asking the questions in the Dash risk checklist:

- Identify early on who the victim is frightened of – ex-partner/partner/family member
- Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.

Revealing the results of the Dask risk checklist to the victim

Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to Marac and Children's Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a

Marac or in another way. **The responsibility for identifying your local referral threshold rests with your local Marac.**

Resources

Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following websites and contact details may be useful to you:

- **National Domestic Violence Helpline** (tel: 0808 2000 247) for assistance with refuge accommodation and advice.
- **'Honour' Helpline** (tel: 0800 5999247) for advice on forced marriage and 'honour' based violence.
- **Sexual Assault Referral Centres** (http://www.rapecrisis.org.uk/Referralcentres2.php) for details on SARCs and to locate your nearest centre.
- **Broken Rainbow** (tel: 08452 604460 / web: www.brokenrainbow.org.uk) for advice for LGBT victims) for advice and support for LGBT victims of domestic abuse.

Asking about types of abuse and risk factors

Physical abuse

We ask about physical abuse in questions 1, 10, 11, 13, 15, 18, 19 and 23.

- Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation.
- You should try and establish if the abuse is getting worse, or happening more often, or the incidents themselves are more serious. If your client is not sure, ask them to document how many incidents there have been in the last year and what took place. They should also consider keeping a diary marking when physical and other incidents take place.
- Try and get a picture of the range of physical abuse that has taken place. The incident that is currently being disclosed may not be the worst thing to have happened.
- The abuse might also be happening to other people in their household, such as their children or siblings or elderly relatives.
- Sometimes violence will be used against a family pet.
- If an incident has just occurred the victim should call 999 for assistance from the police. If the victim has injuries they should try and get them seen and documented by a health professional such as a GP or A&E nurse.

Sexual abuse

We ask about whether the victim is experiencing any form of sexual abuse in question 16.

- Sexual abuse can include the use of threats, force or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons.
- If the victim has suffered sexual abuse you should encourage them to get medical attention and to report this to the police. See above for advice on finding a Sexual Assault Referral Centre which can assist with medical and legal investigations.

Coercion, threats and intimidation

Coercion, threats and intimidation are covered in questions 2, 3, 6, 8, 14, 17, 18, 19, 23 and 24.

- It is important to understand and establish: the fears of the victim/victims in relation to what the perpetrator/s may do; who they are frightened of and who they are frightened for (e.g. children/siblings). Victims usually know the abuser's behaviour better than anyone else which is why this question is significant.
- In cases of 'honour' based violence there may be more than one abuser living in the home or belonging to the wider family and community. This could also include female relatives.

- Stalking and harassment becomes more significant when the abuser is also making threats to harm themselves, the victim or others. They might use phrases such as “If I can’t have you no one else can…”
- Other examples of behaviour that can indicate future harm include obsessive phone calls, texts or emails, uninvited visits to the victim’s home or workplace, loitering and destroying/vandalising property.
- Advise the victim to keep a diary of these threats, when and where they happen, if anyone else was with them and if the threats made them feel frightened.
- Separation is a dangerous time: establish if the victim has tried to separate from the abuser or has been threatened about the consequences of leaving. Being pursued after separation can be particularly dangerous.
- Victims of domestic abuse sometimes tell us that the perpetrators harm pets, damage furniture and this alone makes them frightened without the perpetrator needing to physically hurt them. This kind of intimidation is common and often used as a way to control and frighten.
- Some perpetrators of domestic abuse do not follow court orders or contact arrangements with children. Previous violations may be associated with an increase in risk of future violence.
- Some victims feel frightened and intimidated by the criminal history of their partner/ex-partner. It is important to remember that offenders with a history of violence are at increased risk of harming their partner, even if the past violence was not directed towards intimate partners or family members, except for ‘honour’-based violence, where the perpetrator(s) will commonly have no other recorded criminal history.

Emotional abuse and isolation

We ask about emotional abuse and isolation in questions 4, 5 and 12. This can be experienced at the same time as the other types of abuse. It may be present on its own or it may have started long before any physical violence began. The result of this abuse is that victims can blame themselves and, in order to live with what is happening, minimise and deny how serious it is. As a professional you can assist the victim in beginning to consider the risks the victim and any children may be facing.

- The victim may be being prevented from seeing family or friends, from creating any support networks or prevented from having access to any money.
- Victims of ‘honour’ based violence talk about extreme levels of isolation and being ‘policed’ in the home. This is a significant indicator of future harm and should be taken seriously.
- Due to the abuse and isolation being suffered victims feel like they have no choice but to continue living with the abuser and fear what may happen if they try and leave. This can often have an impact on the victim’s mental health and they might feel depressed or even suicidal.
- Equally the risk to the victim is greater if their partner/ex-partner has mental health problems such as depression and if they abuse drugs or alcohol. This can increase the level of isolation as victims can feel like agencies won’t understand and will judge them. They may feel frightened that revealing this information will get them and their partner into trouble and, if they have children, they may worry that they will be removed. These risks are addressed in questions 21 & 22.

Children and pregnancy

Questions 7, 9 and 18 refer to being pregnant and children and whether there is conflict over child contact.

- The presence of children including stepchildren can increase the risk of domestic abuse for the mother. They too can get caught up in the violence and suffer directly.
- Physical violence can occur for the first time or get worse during pregnancy or for the first few years of the child’s life. There are usually lots of professionals involved during this time, such as health visitors or midwives, who need to be aware of the risks to the victim and children, including an unborn child.
- The perpetrator may use the children to have access to the victim, abusive incidents may occur during child contact visits or there may be a lot of fear and anxiety that the children may be harmed.
- Please follow your local Child Protection Procedures and Guidelines for identifying and making referrals to Children’s Services.

Economic abuse

Economic abuse is covered in question 20.

- Victims of domestic abuse often tell us that they are financially controlled by their partners/ex-partners. Consider how the financial control impacts on the safety options available to them. For example, they may rely on their partner/ex-partner for an income or do not have access to benefits in their own right. The victim might feel like the situation has become worse since their partner/ex-partner lost their job.
- The Citizens Advice Bureau or the local specialist domestic abuse support service will be able to outline to the victim the options relating to their current financial situation and how they might be able to access funds in their own right.

We also have a library of resources and information about training for frontline practitioners at http://safelives.org.uk/practice-support/resources-frontline-domestic-abuse-workers-and-idvas

Other Marac toolkits and resources

If you or someone from your agency attends the Marac meeting, you can download a **Marac Representative's Toolkit** here: http://safelives.org.uk/sites/default/files/resources/Representatives%20toolkit_0.pdf. This essential document troubleshoots practical issues around the whole Marac process.

Other **frontline Practitioner Toolkits** are also available from http://safelives.org.uk/practice-support/resources-marac-meetings/resources-people-referring. These offer a practical introduction to Marac within the context of a professional role. Please signpost colleagues and other agency staff to these toolkits where relevant:

A&E
Ambulance Service
BAMER Services
Children and Young People's Services
Drug and Alcohol
Education
Fire and Rescue Services
Family Intervention Projects
Health Visitors, School Nurses & Community Midwives
Housing
Independent Domestic Violence Advisors
LGBT Services
Marac Chair
Marac Coordinator
Mental Health Services for Adults
Police Officer
Probation
Social Care Services for Adults
Sexual Violence Services
Specialist Domestic Violence Services
Victim Support
Women's Safety Officer

For additional information and materials on Multi-agency risk assessment conferences (Maracs), please see the http://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20%28principles%20only%29%20FINAL.pdf. This provides guidance on the Marac process and forms the basis of the Marac quality assurance process and national standards for Marac.

Ending domestic abuse

SafeLives Dash risk checklist

Aim of the form

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to Marac and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the Marac[1] process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form

Before completing the form for the first time we recommend that you read the full practice guidance and FAQs. These can be downloaded from: http://safelives.org.uk/sites/default/files/resources/FAQs%20about%20Dash%20FINAL.pdf. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended referral criteria to Marac

1. **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to Marac. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. ***This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.*** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.

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

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

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a Marac or in another way. **The responsibility for identifying your local referral threshold rests with your local Marac.**

What this form is not

This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

[1] For further information about Marac please refer to the 10 principles of an effective Marac: http://www.safelives.org.uk/marac/10_Principles_Oct_2011_full.doc

Name of victim: Date: Restricted when complete

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

[2] Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

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

For consideration by professional

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

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

Practitioner's notes

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

The Royal Wolverhampton NHS
NHS Trust

APPENDIX 2 (OP108)

Indicators of Abuse in Adults & Children

The following are potential indicators of domestic abuse which may trigger the need for selective enquiry:

- Frequent appointments for vague symptoms
- Frequent missed appointments
- Injuries inconsistent with explanation of cause
- Patient tries to hide injuries or minimise their extent
- Partner is aggressive or dominant, talks for the patient or refuses to leave the room when asked
- Partner always accompanies patient for no apparent reason
- Patient is submissive and/or reluctant to speak in front of partner; they appear frightened, overly anxious or depressed
- Patient presents with unexplained bruises, whiplash injuries consistent with shaking, areas of erythema consistent with slap injuries, lacerations, burns or multiple injuries at different stages of healing
- Injuries to the breast or abdomen
- Injuries to face, head or neck- common injuries include perforated eardrums, detached retinas
- Recurring sexually transmitted infections or urinary tract infections
- Evidence of sexual abuse
- Hair loss- consistent with hair pulling
- Presentation with alcohol and/or substance abuse, depression, anxiety, self-harm, eating disorders or psychosomatic symptoms
- Obsessive compulsive disorder
- History of behaviour problems or unexplained injuries or abuse affecting children
- Suicide attempts
- History of repeat miscarriages, terminations, still births or pre-term labour
- Poor contraceptive use
- Poor or non-attendance at antenatal clinics
- Non-compliance with treatment
- Early self-discharge from hospital
- Substantial delay exists between time of injury and presentation for treatment
- Review of medical record reveals that patient has presented with repeated 'accidental' injuries

Indicators of Abuse in Children

- Bed wetting/regressive behaviours
- Excessive approval-seeking behaviour/behavioural difficulties
- Evidence of injuries
- Difficulty in sleeping / Easily startled or frightened
- Missed health appointments
- Sadness/Low self-esteem/withdrawn
- Anxiety/unexplained illness i.e. abdominal cramps, headaches
- Neglect
- Drug/Alcohol misuse
- Self-Harm/Suicide thoughts
- Running away from home
- Externalising behaviours-aggression/anti-social
- Internalised behaviours-anxiety/depression
- Poor school attendance/excellent school attendance
- Distrust of authorities
- Low achiever at school
- Pregnancy
- Becoming secretive
- Taking on parental responsibilities
- Social isolation
- Difficulty in starting a new relationship/friendship

The Royal Wolverhampton NHS Trust

Domestic Abuse Support Flowchart

Domestic abuse is disclosed or suspected.

Consider immediate risks e.g., if the victim is in immediate danger of serious injury or death, contact the police using 999.

Facilitate a safe and private environment to discuss the concerns with the victim.

Complete the DASH Risk Assessment with the victim and email the completed DASH to **rwh-tr.safeguarding-team@nhs.net**

A score of 14 or more 'yes' and 'Don't know' answers or your professional judgement indicates that the victim is high risk or if the victim has been heard at MARAC within the last 12 months and there has been a repeat incident.

Complete a MARAC referral and email the completed referral to: **rwh-tr.safeguarding-team@nhs.net**

Report the incident of domestic abuse to the police via 101, regardless of victim consent.

If there are children under the age of 18-years linked to the victim or perpetrator, please complete an e-MARF.

If the victim has care and support needs, or any other vulnerable adults are identified within the household, please complete an SA1 and email it to **rwh-tr.safeguarding-team@nhs.net** and the appropriate Local Authority.

Signpost the victim to specialist community support services.

Consider any appropriate onwards referrals e.g., DALT / Mental health services / homelessness services.

Seek the victim's consent to refer for IDVA support.

Consider safe discharge destination and support the victim to access refuge accommodation if required.

Contact the Safeguarding Team on ext: 85163 if advice is required.

A score of 13 or less indicates that the victim is low or medium risk.

Encourage and support the victim to report the incident of domestic abuse to the police via 101.

If the victim has care and support needs, or any other vulnerable adults are identified within the household, please complete an SA1 and email it to **rwh-tr.safeguarding-team@nhs.net** and the appropriate Local Authority.

If there are children under the age of 18-years linked to the victim or perpetrator, please complete an e-MARF.

Seek the victim's consent to refer for IDVA support.

Signpost the victim to specialist community support services.

Consider any appropriate onwards referrals e.g., DALT / Mental health services / homelessness services.

Contact the Safeguarding Team on ext: 85163 if advice is required.

Safe & Effective | Kind & Caring | Exceeding Expectation

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Victim Name:

WEST MIDLANDS MARAC REFERRAL FORM

NON-POLICE AGENCY

Advice when completing this form

- Fields marked with * are compulsory and forms will not be accepted without this information. If the mandatory information is not given, the referral will be withdrawn and the referring agency requested to resubmit.
- Referral forms will only be accepted in Microsoft Word format.
- Where a risk assessment tool (such as DASH) has been completed, a copy should be submitted along with the referral form.
- The referrer is expected to attend the relevant MARAC to present this case and will be invited if the referral is accepted.
- **On completion, this form should be submitted via secure means only to marac_referrals@west-midlands.pnn.police.uk**
- For advice and guidance, please contact the West Midlands Police MARAC Administration team on 101 ext. 811 3048

About this form

This form should be used to submit a MARAC referral when the risk to a victim of domestic abuse has been assessed as high, either through a risk assessment or professional opinion. It should also be used when an already known high risk victim has suffered a repeat incident from the same perpetrator within 12 months after the last MARAC hearing or by the MARAC Administration team when a MARAC victim has transferred into the West Midlands from another area.

When completed, this form will contain personal information (data) including special category (sensitive) data. You, the referrer, are required to comply with General Data Protection Regulations (GDPR) in the processing (including storage & retention) of this data.

GDPR

Article 5 of the GDPR sets out six key principles which lie at the heart of the general data protection regime. MARAC data will typically be lawfully shared under Article 6 (1) (e) public interest or 6 (1) (f) legitimate interest, depending on whether you are a public sector organisation or voluntary agency. If you are relying on your legitimate interests, you need to be clear as to what these interests are, e.g. your interest in safeguarding victims of domestic abuse, and preventing further victimisation. You will also need to have carried out a 'balancing exercise' where you weigh up the interests of the data subject, and the protection of their rights and freedoms, against your own interest. There is further protection where 'special category' data is shared. This used to be called 'sensitive' data, and includes information about ethnicity, health, sex life or sexual orientation. This protection also applies to information concerning criminal offences. Information may be shared without consent if it is needed on the grounds of substantial public interest, which includes processing for the purposes of preventing or detecting unlawful acts, or safeguarding of children and vulnerable adults. You must have policies in place which govern information sharing with MARAC for either of these reasons.

Compliancy

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

Purpose

The purpose of the MARAC Referral Form is to provide only the relevant information required to enable the MARAC Administrative team to process the personal data and information necessary to assess the threshold of the referral and populate an accurate MARAC agenda. This will then be sent to the relevant agencies listed within the MARAC Terms of Reference, as agreed within the West Midlands MARAC Operating Protocol.

It is the responsibility of the referring agency to be satisfied that the threshold for MARAC is reached (that the victim of domestic abuse is at high risk of serious harm or homicide) before referring; this threshold will also be reviewed by the MARAC team.

Consent

The GDPR sets a high standard for consent. However, when a person is assessed to be at high risk of serious harm or homicide (meeting the MARAC threshold) information can be shared without consent and the client cannot choose to withdraw from the process. In many circumstances, it would increase the risk of the victim suffering further harm if consent were sought or given. If safe, consent may still be sought by the practitioner, however even if consent is not obtained, this referral should still be made.

CONSIDERATIONS FOR REFERRAL				
PRIMARY REASON FOR REFERRAL*	DASH Risk Assessment Score of 14 or more (High)			
HAS A SEPARATE REFERRAL BEEN MADE FOR IDVA SUPPORT?	YES ☐ NO ☐	IF YES, PLEASE PROVIDE DETAILS	IDVA SERVICE	DATE REFERRED
IS THE VICTIM AWARE OF THIS REFERRAL, AND OF YOUR CONCERNS? *	YES ☐ NO ☐	IF NO, PLEASE EXPLAIN WHY NOT		
HAS CONSENT BEEN OBTAINED TO MAKE THIS REFERRAL? *	YES ☐ NO ☐			
PLEASE CONFIRM THE LAWFUL BASIS FOR THE PROCESSING OF THIS PERSONAL INFORMATION * (see GDPR guidance on page 1)	Legitimate Interest			
I, THE REFERRER, CAN CONFIRM THAT WHERE ANY SPECIAL CATEGORY DATA IS SHARED WITHIN THIS REFERRAL FORM, IT IS DONE SO LAWFULLY UNDER SECTION 9(2)(g) OF THE GDPR: PROCESSING IS NECESSARY ON THE GROUNDS OF SUBSTANTIAL PUBLIC INTEREST. CRIMINAL OFFENCE DATA IS SHARED LAWFULLY UNDER SECTION 10 OF GDPR				
YES ☐ NO ☐				

REFERRER INFORMATION			
DATE OF REFERRAL		LAST MARAC DATE (IF REPEAT REFERRAL)	
MARAC LOCALITY	Birmingham East		
REFERRING AGENCY *			
NAME OF REFERRER *			
POSITION / JOB TITLE *			
REFERRER CONTACT NUMBER *			
REFERRER EMAIL *			

RISK ASSESSMENT		
HAS A RISK ASSESSMENT BEEN COMPLETED? *	YES ☐ NO ☐	
	WHAT WAS THE SCORE?	
	WHERE A RISK ASSESSMENT HAS NOT BEEN COMPLETED, PLEASE EXPLAIN WHY THIS WAS NOT POSSIBLE	

VICTIM DETAILS			
NAME * (include all known alias')		DATE OF BIRTH *	
CONTACT NUMBER		IS NUMBER SAFE	YES ☐ NO ☐ UNKNOWN ☐
ALTERNATIVE KNOWN SAFE CONTACT NAME I.E PARENT, FRIEND		ALTERNATIVE SAFE CONTACT NUMBER	
USUAL HOME ADDRESS *		GENDER *	
		LANGUAGE SPOKEN	
		ETHNICITY *	
CURRENT ADDRESS (if different from above)		DISABILITY *	
		LGBT RELATIONSHIP	YES ☐ NO ☐
		GP SURGERY	
OTHER RELEVANT INFORMATION REGARDING MENTAL HEALTH, SUBSTANCE MISUSE OR OTHER SIGNIFICANT ADDITIONAL NEEDS OF THE VICTIM			

PERPETRATOR DETAILS			
NAME * (include all known alias')		DATE OF BIRTH *	
RELATIONSHIP TO VICTIM *		GENDER *	
USUAL HOME ADDRESS *		ETHNICITY	
CURRENT ADDRESS (if different from above)		DISABILITY	

CHILD DETAILS				
NAME *	DOB *	RELATIONSHIP TO		LIVING WITH
		VICTIM	PERPETRATOR	

REASONS FOR REFERRAL	
BRIEFLY EXPLAIN YOUR GROUNDS FOR REFERRAL, I.E YOUR PROFESSIONAL JUDGEMENT OF THE RISK OF DOMESTIC ABUSE *	
PROVIDE DETAILS OF THE MOST RECENT INCIDENT(S) *	
PROVIDE A BRIEF HISTORY OF THE RELATIONSHIP BETWEEN THE VICTIM AND THE OFFENDER *	
DETAILS OF SUPPORT AND SAFEGUARDING *ALREADY* IN PLACE *	
PROVIDE DETAILS OF THE SUPPORT AND SAFEGUARDING REQUIRED FROM MARAC *	
HAS THIS INCIDENT BEEN REPORTED TO THE POLICE EITHER BY THE VICTIM OR THE REFERRING AGENCY? IF NOT, PLEASE PROVIDE THE REASON. *	

RISKS AND TRIGGERS		
RISKS TO VICTIM	RISKS TO CHILDREN	OFFENDER TRIGGERS
☐ Physical ☐ Emotional ☐ Threats ☐ Intimidation ☐ Sexual ☐ Isolation	☐ Physical ☐ Emotional ☐ Threats ☐ Intimidation ☐ Sexual ☐ Isolation	☐ Alcohol ☐ Drugs ☐ Child Contact ☐ Controlling Behaviours ☐ Jealousy ☐ Mental Health ☐ Bereavement ☐ Loss of Employment

POLICE INVOLVEMENT to be completed by Police Safeguarding Team only			
POLICE CRIME REFERENCE NUMBER		SAFEGUARDING OFFICER	
CURRENT OFFENCE			
SIG MARKER ON ADDRESS	YES ☐ NO ☐	NON-MOLESTATION OR RESTRAINING ORDER	NON-MOL ☐ RO ☐
OFFENDER CURRENT DISPOSAL	CHARGED ☐ REMANDED ☐ POLICE BAIL ☐ COURT BAIL ☐ CAUTION ☐ COMMUNITY RESOLUTION ☐ DVPO/DVPN ☐ NFA ☐		
BAIL CONDITIONS			
PNC MARKERS			
OPEN TO DOMESTIC ABUSE OFFENDER MANAGERS	YES ☐ NO ☐		
CHARGES, COURT DATE, SENTENCING SUMMARY			
POLICE HISTORY AND SAFEGUARDING SUMMARY			