SAFEGUARDING DOMESTIC VIOLENCE AND ABUSE POLICY (N-054)

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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

On the 29th April 2021, the Domestic Abuse Bill was given Royal Assent and has been signed into law to form the Domestic Abuse Act (2021). The Domestic Abuse Act, creates a statutory definition of domestic abuse as:

"Any incident or pattern of incidents of controlling, coercive, 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 sexual orientation. The abuse can encompass, but is not limited to **psychological, physical, sexual, economic and emotional forms of abuse.**"

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. From 29 December 2015, coercion and control in a relationship is a criminal offence, carrying a maximum sentence of five years in prison (Serious Crime Act 2015).

Domestic abuse occurs in all groups and sections of society and may be experienced differently, due to, and compounded by, race, sexuality, disability, age, religion, culture, class or mental health. Whilst the majority of abuse is perpetrated by men against women, domestic abuse may also be carried out by women against men, within same sex relationships and child/adolescent on parent violence.

This policy will also link to other forms of harm under the realms of domestic abuse including but not limited to female genital mutilation (FGM) and other harmful practices, forced marriage and honour-based abuse.

Humber Teaching NHS Foundation Trust gained White Ribbon status in November 2020. White Ribbon UK is part of the global White Ribbon movement to end male violence against women. It works through engaging with men and boys, raising awareness, influencing change and providing resources to make change happen. As part of the Trust action plan for White Ribbon, domestic abuse champions have been recruited across Humber Teaching NHS Foundation Trust. Domestic abuse champions form a vital role in ensuring a consistent approach in recognising and responding to domestic abuse.

2. DUTIES AND RESPONSIBILITIES

It is the responsibility of all Humber Teaching NHS Foundation Trust staff to adhere to this policy where domestic abuse is considered or suspected including the outlined enquiring about domestic abuse, assessment of risk and next steps for referrals.

3. ENQUIRY INTO DOMESTIC ABUSE

All Humber Teaching NHS Foundation Trust staff, whether working in acute, primary care or community health, have a professional responsibility if signs of domestic abuse are identified or if things are not adding up, to ask patients alone and in private, about their experience of domestic or other abuse, sensitively. Routine enquiry into domestic violence and abuse is Department of Health policy in maternity and adult mental health services. 'Routine Enquiry' is currently performed by all midwives and health visitors when they come into contact with a family. This policy seeks to extend the use of routine and selective enquiry across Humber Teaching NHS Foundation Trust. This includes the importance of GP Practices in making every contact count.

Women are much more likely to be victim of high risk or severe domestic abuse (Safelives 2015) with seven women killed per month by a current or former partner (ONS 2016) although it is acknowledged that male victims are much less likely to disclose domestic abuse. For these reasons, the policy outlines the approach for routine and selective enquiry into domestic abuse.

3.1. What is routine enquiry?

Routine enquiry refers to asking all women (aged 16 years and over) about their experience of domestic abuse, regardless of whether or not there are any signs of abuse, or whether abuse is suspected. Also commonly known as 'screening', this approach particularly helps to increase the rates of identification within vulnerable groups and very much aligns to the principles of the early help and intervention model.

Evidence from where routine enquiry has been implemented suggests that most women do not mind being asked when it is explained that all women are asked because domestic abuse is so widespread, yet it is often hidden (Westmarland, Hester and Reid 2004). Research shows on average, victims experience 50 incidents of abuse before getting effective help (Walby and Allen 2004).

Routinely enquiring may be the only opportunity for the woman to tell someone about what she is experiencing and seek help. However, remember that it is never appropriate (and can be dangerous) to ask her about domestic abuse if she is accompanied by her partner or someone else (including children). In this case, another later opportunity should be made to speak to her alone or pass your concerns onto another professional who could do so.

3.2. Advantages of routine enquiry

Routine enquiry has the potential to:

- give **all** women basic information about the unacceptability of domestic abuse and that abuse is not just about physical violence;
- give **all** women information that they can share with their friends, family, neighbour; even if it is not personally relevant to them;
- help reduce the stigma associated with abuse and the hidden nature of domestic and sexual abuse;
- inform women experiencing abuse that they are not alone in their experience and that there are services available to support in changing their situation.

3.3. Selective Enquiry

Selective enquiry includes asking questions when indicators of abuse have been observed **(see Appendix 1),** or when a disclosure is made and safe questioning is required. There are important differences between male violence against women and female violence against men, namely the amount, severity and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, (2017); Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2019). Selective enquiry of domestic abuse is more appropriate to men as:

- men do not experience similar levels of injuries (Walby & Towers, 2017; Walby & Allen, 2004)
- the dynamics of abuse for men and women are different – women are more likely to be fearful of their partners and to be subjected to coercive controlling behaviours and experience sustained abuse, resulting in considerable implications in particular for mental health and substance misuse (Dobash & Dobash, 2004)
- women are more likely to experience sexual violence and degradation (Dobash & Dobash, (2004) Hester, (2013); Myhill, (2015); Myhill, (2017).

3.4. Key principles underpinning domestic abuse enquiry

- Ensure the safety of the service user being asked (and any dependent children they have) is the prime consideration;
- Ensure privacy – the service user is unlikely to disclose if others might hear them;
- Show the service user you are relaxed and ready to listen. If you appear anxious and rushed she will not feel safe to disclose;
- Be respectful and listen carefully to what you are being told;
- Seek to empower the service user, not make decisions for them;
- Remain non-judgmental – never imply the service is to blame for the abuse she is experiencing; Consider the need for an interpreter – do not use anyone accompanying the service user to interpret for them;
- Respect confidentiality;
- If/when the service user discloses their experience of abuse, validate what they are saying; tell them you are glad that they have told you and believe them;
- Do not rush or pressure the service user into making any decisions;
- Do not take any action that could place you or colleagues at risk of violence.

3.5. Creating an environment for domestic abuse enquiry

The National institute of clinical excellence (NICE 2014) guidance into domestic violence and abuse includes the recommendations that health and social care services should create a safe environment for disclosure.

This should include:

- Clear display of information in waiting areas and other suitable places about support on offer to those affected by domestic abuse;
- This should include both local and national sources of support and should include information to groups who may find it more difficult to disclose;
- Ensure information is provided in a range of formats and locally used languages;
- Consider discreet methods for provision of information;
- Ensure all frontline staff are aware of local services for domestic abuse;
- Ensure staff are able to access training around domestic abuse to recognise indicators of abuse;
- Ensure staff have access to training around enquiry into domestic abuse.

Contact with service users on Humber Teaching NHS Foundation Trust premises should ensure that the environment is a quiet and confidential area and limit the potential for consultation disruption. Cyber safety is becoming an area of increasing vigilance so request for switching off devices such as mobile phones may assist a safer disclosure. Further information can be sought at Assessing for Tech Abuse. If the practitioner deems it not safe to ask at these given times, the practitioner must ask at the next safe available opportunity.

3.6. Implementation of domestic abuse enquiry

Humber Teaching NHS Foundation Trust staff are encouraged to remember that success is asking the service user about domestic abuse in a safe way no matter what the response or what help is accepted by them. This sends a strong message to them that domestic abuse is a serious issue. Just asking the question may change their thinking about what is happening to them. It also sends the message that there is help available. The service user may not accept help on the day but may ask for help in the future.

3.7. Framing and preparing the question

Framing the question provides permissions to the Humber Teaching NHS Foundation Trust staff for introduction of the topic of domestic abuse by use of additional resources such as posters. Service users should be prepared with the reason for asking, your role (to support and help keep people safe). Be honest, confidentiality remains but if there is serious risk or risk to a child you will

need to share the information. See **Appendix 2** for examples of framing and direct questions for domestic abuse enquiry

3.8. Virtual consultation

Humber Teaching NHS Foundation Trust acknowledges that the global pandemic and restrictions led to reduced opportunities for face-to-face consultations. In order to ensure Humber Teaching NHS Foundation Trust staff are vigilant to potential indicators of domestic abuse through virtual contact, please see **Appendix 3.**

4. RESPONDING TO DOMESTIC ABUSE

4.1. Responding to disclosure from a victim

Where a service user discloses and requests support, Humber Teaching NHS Foundation Trust staff will ensure safe contact details are recorded and referral is made to the local domestic abuse service**,** (this where possible, should take place with the service user as opposed to signposting)**.** Local and national support services can be seen in **Appendix 4**. All relevant safeguarding processes should also be considered (see 6.1 and 6.2).

Whilst adults who are deemed to have capacity in regard to having contact/being in a relationship, whilst consent is required for safeguarding adult referrals, if it is deemed that a criminal offence has occurred, i.e. significant bruising, strangulation mark, but the service user does not give consent for information to be shared, it is clear that there is still a duty of care to report all such incidents to the Police.

If staff are presented with evidence of injuries or witness a criminal act taking place then, regardless of the consent of the patient, this should be reported to the police or followed up with the Local Authority if the situation concerns a child. This might apply to witnessing an assault, seeing evidence of injuries, seeing or hearing evidence or accounts of domestic abuse or sexual assault.

There may be occasions where service user family members also disclose domestic abuse, they may not be open to Humber Teaching NHS Foundation Trust services, however, a duty of care would still apply to provide the same advice around local contact details and in the event of an emergency, contacting the Police. Advice should be sought from the Humber safeguarding team in such circumstances.

If a patient doesn't give consent for the police to be contacted staff still have a duty to report the incident, particularly if there is evidence of injury, as the patient could be at further risk of assault. The public could also be at risk and appropriate support and protection needs to be arranged with police, local domestic abuse services and MARAC.

Domestic abuse has a direct correlation with homicide and child abuse and should always be given a high risk consideration when there is evidence of domestic abuse occurring.

This should always be explained clearly and transparently to the patient giving the rationale:

- Duty of care from staff
- Risk to self or others
- Legal responsibilities of the staff
- Seeking appropriate advice and/or protection planning for the patient

Appropriate support/advice should always be sought by staff from:

- Line manager
- Safeguarding

- Security staff
- On call manager
- Information Governance/Legal team

4.2. Assessing Risk

Coercive Control

There may be occasions where a service user discloses arguments or details around their relationship, this may be with an intimate or former partner or a family member. They may describe the relationship as controlling. If the environment is safe to allow further discussion (the conversation cannot be heard by anyone over the age of two years) exploration is helpful to consider whether there may be indicators of coercive control.

Coercive control is a high risk indicator in domestic homicides. It consists of three elements

- Control (rules)
- Challenge (breaking rules whether intentional or unintentional)
- Consequence (what happens if the rule is broken – may involve emotional abuse sulking, restrictions (not allowing contact with friends or family), physical violence or threats of violence)

It is therefore helpful to enquire about the above in order to understand what the rules and consequences involve.

DASH Risk Assessment

Where domestic abuse disclosures are made or it is known that domestic abuse has occurred, Humber Teaching NHS Foundation Trust staff should consider the completion of a domestic abuse, stalking, harassment and honour-based abuse (DASH) risk assessment. The Safelives - DASH risk assessment (**Appendix 5**) will assist front line practitioners identify high risk cases of domestic abuse, stalking and 'honour' based violence. The risk assessment once completed (all questions) will also help those practitioners in deciding which cases should be referred to MARAC, and the support that may be required. The importance of clinical judgement remains unchanged irrespective of the completed Safelives - DASH risk assessment if the practitioner remains concerned. Before completing the form for the first time it is recommended that the practitioner reads the full practice guidance and FAQ, these can be downloaded from: MARAC FAQs Where risk assessment is not made, it should be documented why this has not taken place.

A risk assessment should judge whether the concerns are significant that a referral should be made to a multi-agency risk assessment conference (**MARAC**). A risk matrix produced by Safelives in conjunction with the DASH risk assessment can be accessed in **Appendix 6.**

Suicide Risk

Domestic abuse is likely to have significant impact upon the mental health of those living with this day to day. Research from domestic abuse related deaths has shown an increase risk of suicide to the non-abusive parent where there is fear for the removal of children from their care. It is therefore essential when assessing risk, to consider the risk of mental health and suicide. Relevant mental health referrals and awareness should be discussed, this may include discussion of the crisis mental health team to ensure safety planning.

Non-fatal strangulation

Non-fatal strangulation is a high risk method of control that is used to restrictive a victim from breathing, this may include, drowning, choking, smothering and restriction ability to breathe. Non-fatal strangulation became a separate offence on 7th June 2022. Each episode of non-fatal strangulation increases the risk of domestic homicide by 700%, therefore it remains a high risk indicator. Guidelines for clinical management of non-fatal strangulation can be found here - Non Fatal Strangulation Guidelines - Acute Emergency (Feb 24)

Local arrangements are currently being reviewed.

Stalking
Stalking is a high risk indicator and an escalation of behaviour, often used when control of the victim has been lost within the eight stage homicide timeline (Monckton-Smith). This includes behaviours such as breaking legal order, such as contacting via text message. Where a threat is made and carried out (threats to turn up to someones place of work and doing so) this suggests a significant increase in risk. All such incidents of stalking should be reported to the Police. Further advice can be obtained via suzylamplugh.org

4.3. Where there is no disclosure following enquiry

Humber Teaching NHS Foundation Trust recognises that it takes on average 30 occasions before disclosure is likely to take place; where Humber Teaching NHS Foundation Trust staff have concerns over injuries to adults that appear non-accidental, explanation for injury shall be documented in their own words using quotation marks. Further attempts should be made to provide opportunity for safe disclosure; this may involve further appointment with arrangement of support from the local independent domestic violence advocate (IDVA) who can be accessed via local domestic abuse services. Where concerns remain over non-accidental injury to a child, the child's voice should be obtained where appropriate and safe to do so, child safeguarding procedures in such cases should be followed.

4.4. Service users from out of area

Humber Teaching NHS Foundation Trust recognises that victims and survivors of domestic abuse may frequently move around the country due to the risk of domestic abuse. It is therefore essential that Humber Teaching NHS Foundation Trust staff follow routine enquiry (as above). Where domestic abuse risk is high and the service user has previously been discussed at MARAC, a MARAC to MARAC transfer should take place in order to allow local services to assess the risk at this current time. Humber Teaching NHS Foundation Trust staff working with service users who disclose domestic abuse should liaise with the relevant MARAC contacts (below) to see whether this has taken place. The Humber Teaching NHS Foundation Trust safeguarding team can be contacted at any point for advice.

North Yorkshire
maracyork@northyorkshire.pnn.police.uk
maracharrogatecraven@northyorkshire.pnn.police.uk
marachambrich@northyorkshire.pnn.police.uk
maracselby@northyorkshire.pnn.police.uk
maracscarborough@northyorkshire.pnn.police.uk

Hull
HullDAP.MARACReferrals@hullcc.gov.uk

East Riding
marac@eastriding.gov.uk

5. RESPONDING TO PERPETRATORS

5.1. Key principles of responding to perpetrators

There may be occasions where service users indicate that they have previously or are currently a perpetrator of abuse. Humber Teaching NHS Foundation Trust staff responses to any disclosure of abuse could be significant in encouraging responsibility and motivating a perpetrator to change. However, before seeking or enabling a disclosure from a person you suspect may be a perpetrator of domestic abuse, you should be confident. You should also consider your own safety and that of the victim and any children. Use motivational interviewing approaches to be persuasive but supportive.

Use incisive moments to intervene. A simple set of skills is needed for this approach, but the key principles are:

- express empathy through reflective listening;
- identify discrepancy between the client's goals or values and their current behaviour and explore it further;
- avoid argument and direct confrontation;
- adjust to the client's resistance rather than opposing it directly;
- support self-efficacy and optimism.

5.2. Potential indicators

If the patient presents with a problem such as drinking, carer issues, stress or depression, but does not refer to their abusive behaviour, these are useful questions to ask:

- How is this drinking/stress at work/depression affecting how you are with your family and spouse?
- When you feel like that, what do you do?
- When you feel like that, how do you behave?
- Do you find yourself shouting/smashing things?
- Do you ever feel violent towards a particular person?
- It sounds like you want to make some changes for your benefit and for your partner/family. What choices do you have? What can you do about it? What help would you like to make these changes?

5.3. Responding to domestic abuse disclosure

If the patient has stated that domestic abuse is an issue and they are not the victim, these are useful questions to ask:

- How does your behaviour make you feel?
- How does your behaviour affect people close to you?
- How do alcohol/drugs affect your behaviour?
- What do you think will help you change your behaviour?

5.4. Direct questions

If the patient responds openly to these prompting questions, more direct questions relating to heightened risk factors may be appropriate:

- Do you feel unhappy about your partner seeing friends or family – do you ever try to stop them?
- Have you assaulted your partner in front of the children?
- Have you ever assaulted or threatened your partner with a knife or other weapon?
- Did your behaviour change towards your partner during pregnancy?

5.5. Sources of support

Where a perpetrator acknowledges their abusive behaviours and wants to seek help in order to address their own behaviour, knowledge of support services is essential (refer to **Appendix 4** for national and local support services for perpetrators).

6. REFERRALS AND SAFETY PLANNING

Following the completion of a DASH risk assessment, professionals can help minimise the risk of future domestic abuse incidents by helping victims consider and develop a personal safety plan (**see Appendix 7**), the local domestic abuse services may assist if the service user is accepting of this support, however, Humber Teaching NHS Foundation Trust services may be key in assisting

with safety plans, for example where the service user has learning disabilities or health vulnerabilities. This helps increase the safety of the victim within the relationship or if the victim decides to leave which is clearly evidenced as a high risk point for victims of domestic abuse. When a service user does disclose that they are experiencing abuse, it is important that they receive an immediate response that is sensitive to their needs.

Each individual's level of need will depend on their own unique experiences of abuse, the level of risk they currently face and their identity. All individuals, however, require support to develop a safety and support plan that considers all their options and minimises risk.

As domestic abuse victims/survivors have been subjected to patterns of coercive control from their abusers, an options-based approach to safety and support planning allows them to choose what is best for them and enables their empowerment and self-protection in the long-term.

This approach must underpin any response, except where significant child or adult safeguarding considerations over-ride this. The professional responding to the disclosure may not necessarily be the best placed person to undertake support and safety planning however, at the very least should assist the service user in identifying who can support them by referring as appropriate.

6.1. Children and domestic abuse

Children living with domestic abuse are not merely bystanders, but victims within their own right (DA Act 2021). Children who are experiencing domestic abuse may benefit from a range of support and services and may need safeguarding from significant harm. The referral procedure is as per the LSCP Guidelines and Procedures demonstrated in the **Appendix 8**.

Where it is deemed that children and young people have a lower level of need, they should be supported outside of the child protection process. The staff member should seek agreement from the non-abusing parent or the young person themselves (if they have capacity for those aged 16 and over or if they are considered to be Gillick competent under the age of 16 years), to complete the Early Help Assessment.

Practitioners must be aware that at times they will need to be extra vigilant regarding the possibility of increasing risk to children and young people, and the non-abusing parent, should the assessment include the perpetrator. It is therefore strongly advised that an early help assessment is not undertaken prior to consulting with the Early Help Team if the perpetrator is living in the family home.

Issues of domestic abuse should always be discussed with line managers and within safeguarding supervision with details recorded clearly in the records.

A report to the Police should be considered if there is evidence of immediate significant risk to the individual or family.

The Early Help Assessment – EHA process gives agencies working with children and young people a common language to understand both the needs of the child/young person and what is happening to them, using three domains:

- the developmental needs of the child;
- the parental capacity (or caregiver capacity) to meet the child's needs;
- the impact of the wider family and environmental factors on both parenting capacity and the child's development.

The EHA requires the consent of families. If parents and/or the child do not consent to an EHA, then the person undertaking the assessment should make a judgment as to whether, without help, the needs of the child/young person will escalate. If so, a referral into local authority children's social care may be necessary.

6.2. Adults and domestic abuse

Consideration for adult safeguarding procedures should be made for those who are aged 18 and over and meet the criteria for safeguarding under the Care Act (2014):

1. The adult has care or support needs;
2. Is at risk of abuse and or neglect;
3. Is unable due to their care and support needs to protect themselves against the abuse and or neglect (see **Appendix 9** for referral procedures).

Your response to an older person, or a person with disability, should be the same as for younger people, but with an added awareness that people in vulnerable circumstances face greater barriers to disclosing abuse or accepting support. Fear of unknown intervention can feel riskier than the known fear of abuse, especially where perpetrators might be depended on as carers and also as relatives or friends. It is not unusual for vulnerable people in such circumstances to deny that there is a problem, even in very serious cases.

7. MARAC PROCESS

It is accepted that Humber Teaching NHS Foundation Trust staff working with the victim will not act as the caseworker in respect of domestic abuse, however, they will form part of the multi-agency care intervention and risk management plan around the victim if they have case involvement and it is specific to their role. A multi-agency risk assessment conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health safeguarding, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

The three main objectives of MARAC include:

- To gather detailed and relevant information from victims, that can be shared with other agencies;
- To identify those who will need more intensive support;
- To make agencies aware of the most dangerous offenders.

Information gathered during the risk assessment is shared among relevant agencies to promote the safety of the victim and their families. A copy of the referral to MARAC is included in **Appendix 10**.

Humber Teaching NHS Foundation Trust may be requested to complete a research form in respect of their involvement in the care of the service user. Actions requested of Humber Teaching NHS Foundation Trust should be completed within 5 working days of the MARAC.

8. USE OF INTERPRETERS

Domestic Homicide reviews across the nation have highlighted some cases where the inability to communicate meant a victim experiencing domestic abuse was unable to access the support they needed. The use of family members to interpret is strictly prohibited. Female interpreters should always be used for enquiries about domestic abuse where the victim is also female. A clear script needs to be developed for women who may have a different cultural understanding of domestic abuse. Interpreters may dilute the responses provided by the victim or may offer their own views. Where a lengthy response is interpreted back in limited translation this should raise further query.

Please refer to Trust policy when arranging interpreters.

Interpreter Services - Hull and East Riding

Interpreting Services - Scarborough, Ryedale and Whitby

9. RECORD KEEPING

Particular care must be taken to ensure detailed, accurate and clear records in all cases where domestic abuse is an issue. It is important to be clear about whom the victim and the alleged perpetrator are and that their names are documented in full. Reference must be made to record keeping guidelines relating to the health workers professional body and the Trust. In those cases where information needs to be 'hidden' to protect the victim and their children, refer to your organisations/Trusts policy on record keeping and data protection. If MARAC meeting records are shared and attached to patient records, they should not be provided under patient request for records.

It is important that when recording details around domestic abuse, all efforts are taken to use appropriate language and terminology that does not imply the person who has experience domestic abuse is complicit in anyway. Examples of this could be:

Inappropriate terms / phrase / sentence	**Suggested alternative**
Not prioritising the safety/needs of their children	The intensity of the abuse has impacted on the person accessing services to protect their child
They allowed the perpetrator into their home	They had no other choice but to allow the perpetrator into the home OR access was granted due to the risk of escalation
Victim/Survivor	The person may prefer you to use 'someone who has experienced domestic abuse'
Why did you not ring the Police?	What prevented you from being able to phone the Police/Call for help?

Language should reflect the presence of coercion and lack of control many people experiencing domestic abuse have, and must recognise the severity of the impact domestic violence can have on an individual and their children.

Victim blaming language, such as the terms given as examples above, may reinforce the messages given by perpetrators of domestic abuse around shame and guilt which could in turn prevent the person experiencing domestic abuse from disclosing it to others.

10. FORCED MARRIAGE/HONOUR-BASED ABUSE AND FEMALE GENITAL MUTILATION

Humber Teaching NHS Foundation Trust recognises that the above issues are also encompassed within domestic abuse. Further guidance is available through LSCP policies and procedures (read more about these areas in **Appendix 11**

11. STAFF AND DOMESTIC ABUSE

If the alleged perpetrator is an employee of Humber Teaching NHS Foundation Trust, the Trust Safeguarding Team must be consulted. Consideration will be given to the process outlined in the Trust Allegations against Staff Policy and possible liaison with Human Resources and Service managers. See further information highlighted within **Appendix 12**.
See 'Staff affected by Domestic Abuse – Guidance for Managers' (G438) for more information.

12. TRAINING AND SUPERVISION

It is important that Trust staff are not isolated or burdened in making decisions. The majority of Trust staff work in teams where they should have access to Safeguarding adult and children supervision, allowing a case to be discussed. Ad hoc supervision can be sought from the Safeguarding Team within the Trust. Advice is also available from the Local Authority Safeguarding Adult and Child Teams.

The Trust works with the Local Safeguarding Adult Boards (LSABs) and Children Partnerships (LSCPs) to provide appropriate training for staff in this complex and challenging area. All practitioners should adhere to mandatory training requirements of the Trust. Additional training regarding domestic abuse and domestic abuse and children is available on request by the LSCP.

13. CONFIDENTIALITY AND INFORMATION SHARING

Any actions undertaken by staff in respect of domestic abuse will only be undertaken with the consent of the service user unless the risk assessment identifies that there is a significant risk or a child's or adult's health and well-being, or the capacity of the individual is such that he/she is unable to consent. The Mental Capacity Act applies to anyone over the age of 16. Decisions about a young person's capacity and best interests can be made in the same way as for any adult.

When there are reasons to believe that a child and/or a young person is at risk as a result of domestic abuse, child protection must take precedence over confidentiality, and LSCP child protection guidelines and protocols must be followed.

Where concerns arise around where a staff member or service user is in an intimate relationship with someone with extensive risks of domestic abuse, applications to the Police for information sharing can be used under Clare's Law (**see Appendix13**).

Further information can be found in the Trust Mental Capacity Act and Best Interests Decision Making Policy.

14. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

15. MENTAL CAPACITY

This policy should be considered in line with Trust MCA policy and guidance. The Mental Capacity Act applies to anyone over the age of 16. Decisions about a young person's capacity and best interests can be made in the same way as for any adult. Young people over 16 years old are presumed to have capacity to consent to surgical, medical or dental treatment and to associated procedures, such as nursing care (Family Law Reform Act 1969).

Some procedures are not covered by this, but by an assessment of 'Gillick competence'. This assessment is used with people under 16 years of age.

16. IMPLEMENTATION

This guidance will be discussed within the mandatory safeguarding training programme, through briefings and updates to clinical teams and through safeguarding children supervision. It will be available on the intranet and will link to the Local Safeguarding Children Partnership procedures and guidance.

17. MONITORING, AUDIT AND COMPLIANCE

Information regarding monitoring and compliance with this policy will be included in quarterly performance reports from the Safeguarding Team to the Trust Quality & Patient Safety Group and the Trust Safeguarding Forum. This will include:

- Any new or ongoing domestic homicide reviews;
- Quality of and any risk areas associated with MARAC;
- Any relevant audits undertaken within the time period;
- Impact of new guidance and legislation relating to domestic abuse.

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Appendix 1 - Indicators of Domestic Abuse

INDICATORS OF DOMESTIC ABUSE	
Physical	Traumatic injuries with vague or implausible explanations Old injuries, multiple injuries at different stages of healing Bruises, abrasions, bite marks, strangulation, old injuries, nasal fractures, burns, Head/face/neck injuries Injuries to abdomen, genitals, chest or defence wounds on forearms Sexually transmitted infections including recurrent urinary tract infections Unwanted pregnancies, repeated miscarriages and terminations Gynaecological problems including chronic pelvic pain, sexual function issues
Emotional	Depression and anxiety, eating disorders, sleep disturbance, irritable bowel syndrome Tiredness Post-traumatic stress disorder Chronic pain Suicidal ideation or attempts, deliberate self-harm Substance/alcohol misuse Feelings of dependency, reports of isolation from family/friends Anger, guilt, loss of hope, shame, loss of confidence/self esteem
Behavioural	Repeat attenders (unplanned care) Frequently missed appointments/no access visits Repeated attendances for emergency contraception Vague complaints or symptoms Minimising or hiding injuries Non-compliance with treatment or advice Reluctant/afraid to speak in front of partner or family member
Coercive control	Aggressive/dominant partner or family member (speaks for patient, refuses to leave room, always at appointments) Perpetrator asserting contraceptive control or medication Repeated pregnancy/miscarriage Consider substance/alcohol as form of control Isolated from friends and family
Economic	Expresses high levels of concern about where money is coming from Says they have less access to or control over their money Prioritises buying items or paying bills that may not seem essential Leaves work when they liked their job can’t access basic necessities Is especially concerned about access to food and other goods

Appendix 2 - Framing, introducing and enquiring about domestic abuse

Framing 'You may have seen our poster about domestic abuse, which can include emotional, financial, sexual, physical abuse or anything that makes you feel uncomfortable and frightened – we are now asking all women who we see whether they have experienced domestic abuse in the past or present.'

Introducing 'I don't know whether this is a problem for you, but we are asking all women about their experiences of abuse, because we know it can be difficult to ask for help.'

Preparing – Prepare them with the reason for asking, your role (to support and help keep people safe). Be honest, confidentiality remains but if there is serious risk or risk to a child you will need to share the information

Examples of direct question

- ***Are you in a relationship with someone who hurts or threatens you?***
- ***Did someone cause those injuries to you?***
- ***Are you afraid or frightened of someone's behaviour?***
- ***What happens at home if you make a mistake or break something?***
- ***Have you ever been physically hurt by someone you are in, or was in, a relationship with?'***
- ***Do they ever say or do anything that makes you feel afraid?***
- ***Do you feel frightened of someone at home?***
- ***Do you feel that you are in danger?***
- ***Has anyone ever threatened you or someone you care about?***
- ***Do you feel controlled or isolated from others by someone?***
- ***Does anyone ever insult you and put you down?***

Appendix 3 - Assessing Concerns During Virtual Contacts

	YES	NO	NO INFORMATION? DON'T KNOW
PRE SCREENING – CONSIDER INCREASED VULNERABILITY TO DOMESTIC ABUSE			
Staff member has concerns of domestic abuse with no disclosure			
History of domestic abuse			
Currently discussed at MARAC (multi agency risk assessment conference)			
Historically discussed at MARAC?			
No disclosure of domestic abuse but partner or close family member always in attendance and reluctant to leave previous appointments			
History of unexplained injuries			
History or presentation of anxiety/depression			
History of gynaecological issues			
History of frequent, pregnancy, miscarriage, termination			
Partner has previous history of domestic abuse			
Relationship has progressed very quickly (i.e. partner moves in after short period)			
Social isolation			
USING A PHONE CONSULTATION			
Service user sounds anxious on the phone provides only limited answers to conversation			
Service user appears guarded or you can hear that their conversation is being directed by another person			
You hear sounds of possible altercations or vehement disagreements			
Background sounds of persistent infant crying and/or a parent expressing anxiety about how to cope with this			
Consultations where a family member is providing the 'translation' for a non-English speaking service user – particularly concerning if any of above risk factors are also present			
USING A VIDEO CONSULTATION			
Are there signs of damage in the property?			
Do you know who else is present in the room? Are they someone you recognise from the family? Check if the patient is happy to proceed with the consultation if other people are around			
Does the service user appear to be in pain? Any visible injuries?			
How does the patient present? Is this very different to usual? Do they appear guarded or watchful?			
Prompts for consideration of domestic abuse (only to be asked where it is known that the patient/client is alone) *"Can you tell me how you got those injuries?"* *"Is anything worrying you or making you feel anxious/frightened?"* *"Can you tell me who else is living in or visiting the home?"*			
Consider additional safeguarding features for children or adults			
Families where there are family members/children with learning difficulties or disabilities			
Young, unsupported parents especially with very small children			
Carers with limited support or individuals who are socially isolated			
Families whose children are or have previously been subject to Child Protection Plans or adults who are known to have been at risk			

Children or adult with care and support needs where there is a history of them not being brought to medical appointments			
Emotional or mental health problems in parents or children– particularly if you are aware that these are being exacerbated by lockdown and limited access to support			
Are there new people who appear to have moved into the service user's home?			
Are there apparent financial issues for the family or does a service user appear to not have control over their finances?			
Situations where there are other safeguarding concerns such as exploitation or modern-day slavery			
Increase or decrease in presentation to services compared to pre-Covid levels			
How does the room look? Is there any obvious evidence of alcohol or drug use? Are there any obvious environmental risks, particularly if there are young children in the home?			
Are there concerns around clutter or hoarding within the home environment?			
Concerns that the individual does not appear to be looking after themselves?			
Concerns around dementia or impact on mental capacity			
If the consultation is about a child, is the child seen in the consultation or is the parent unwilling for them to be seen? If the child is seen, how do they look? Are they clothed appropriately for the season? How are the interactions with their parent? Did there appear to be any toys for them to play with? Is their presentation different to usual? (consider above for an adult and carer)			

Trust your instincts

If something doesn't feel right…it probably isn't right!

You could:

- *Check it out with any other professional involved with the family (Health Visitor, Social Worker, etc.) – do they have any other information about how things are going?*
- *Go back to the family – follow up your instincts and check in again with a call or text*
- *Suggest that the patient contacts you via email or text – this may be easier than them making a further phone/video call*
- *If possible gain a safe word from the client and agree a safe time for further contact*
- *Offer a face-to- face consultation*
- *Check it out with the Safeguarding Team HNF-TR.SafeguardingHumber@nhs.net*

Appendix 4 - Contact Details of National Services for Families Living with Domestic Abuse

Service	Description	Contact
National Service		
24-hour National Domestic Violence Helpline Freephone	A service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf. It is run in partnership between Women's Aid and Refuge. Callers may firstly hear an answerphone message before speaking to a person.	0808 2000 247 https://www.nationaldahelpline.org.uk/
Men's Advice Line Freephone	A confidential helpline for all men experiencing domestic violence by a current or ex-partner. This includes all men – in heterosexual or same-sex relationships. Offers emotional support, practical advice and information on a wide range of services for further help and support.	0808 801 0327 Days and times of phone support varies. https://mensadviceline.org.uk/
Respect Freephone	A confidential helpline for people who are abusive and/or violent towards their partners. Offers information and advice to support perpetrators to stop their violence and change their abusive behaviours. The main focus is to increase the safety of those experiencing domestic violence.	0808 802 4040 Days and times of phone support vary. www.respectphoneline.org.uk
Forced marriage unit	Joint initiative between the Foreign Office and Home Office. It assists actual and potential victims of forced marriage, as well as professionals working in the social, educational and health sectors.	020 7008 0151 fmu@fco.gov.uk http://gov.uk/forced-marriage
Karma Nirvana	Karma Nirvana is an award-winning National charity supporting victims of honour-based abuse and forced marriage	0800 5999247 info@karmanirvana.org.uk
Local Services		
Domestic Violence and Abuse Partnership (East Riding)		
Independent domestic abuse services (North Yorks)		
Domestic Abuse Partnership (Hull)- Hull DAP		(01482) 318759
Domestic Violence Adult Service		(01482) 396368
Open Door-Bransholme Women's Centre		(01482) 828755
Sexual Assault Referral Centre CASA (Care After Sexual Assault)		casasuite.sarc@nhs.net 0330 223 0181
Rape Crisis		(01482) 329990
Women's Aid (Hull)		(01482) 446099 http://www.hullwomensaid.org/
Support for Young People		
Respect not Fear	Website for young people about domestic violence.	respectnotfear.co.uk
The Hideout	Women's Aid website to help young people understand domestic abuse, and how to take positive action if it's happening to them.	thehideout.org.uk
Support for Perpetrators		
The Respect: Confidential Helpline		0808 8024040 or www.respectphoneline.org.uk .
East Riding—Prevention of Domestic Abuse Service (PODAS)		https://www.eastriding.gov.uk/living/crime-and-community-safety/domestic-violence/prevention-of-domestic-abuse-service/
Hull—Strength to Change		http://www.hullstrengthtochange.org/html/
North Yorkshire—Foundation		https://www.foundationuk.org/team/choices-domestic-abuse-perpetrator-programme/

Appendix 5 - Domestic Abuse, Stalking, Harassment and Honour-Based Abuse Risk Assessment

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) ☐				

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	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				

Appendix 6 - Risk Matrix

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

Appendix 7 - Safety Plans

A personal safety plan is a way of helping victims to protect themselves/and their children. It helps them plan for the possibility of future violence and abuse. It also helps them to think about how they can increase their safety either within the relationship, or if they decide to leave.

Safety plans will include measures such as emergency phone numbers, SAFE passwords, an emergency bag for leaving quickly, knowing safe routes and safe rooms, alarms, markers on police systems, internet and mobile phone safety. The victim may also benefit from keeping a diary of incidents, provided it is safe to do so, as this can support civil and criminal proceedings. The safer a victim feels the more likely they are to make positive changes.

Safety Planning Suspected Forced Marriage	
Firstly, advise her/him not to travel overseas and inform her of the difficulties and abuse she/he may face if she/he goes. If safe to do so, give her/him the contact details of the nearest Embassy/British High Commission of their destination and the Forced Marriage Unit in the UK.	
Gather as much information about the family (this will need to be gathered discreetly) including: • Full name and date of birth of the woman/man under threat • Her/his father's name • Any addresses where she/he may be staying overseas • Potential spouse's name • Date of the proposed wedding • The name of the potential spouse's father (if known) • Addresses of her extended family in the UK and overseas • Details of any travel plans and people likely to accompany her/him • Names and addresses of any close relatives remaining in the UK • A safe means by which contact be made, e.g. a secret mobile telephone that will function overseas. Record the number • An estimated return date. Ask that she/he will contact you without fail on their return	
Offer to make an appointment for a future date and discuss with her what you should do if she/he does not attend	
It is also important to gather information from her/him that she/he would only be aware of (this may assist any subsequent interview at an Embassy/British High Commission in the case of another person of the same sex and age is produced pretending to be her/him)	

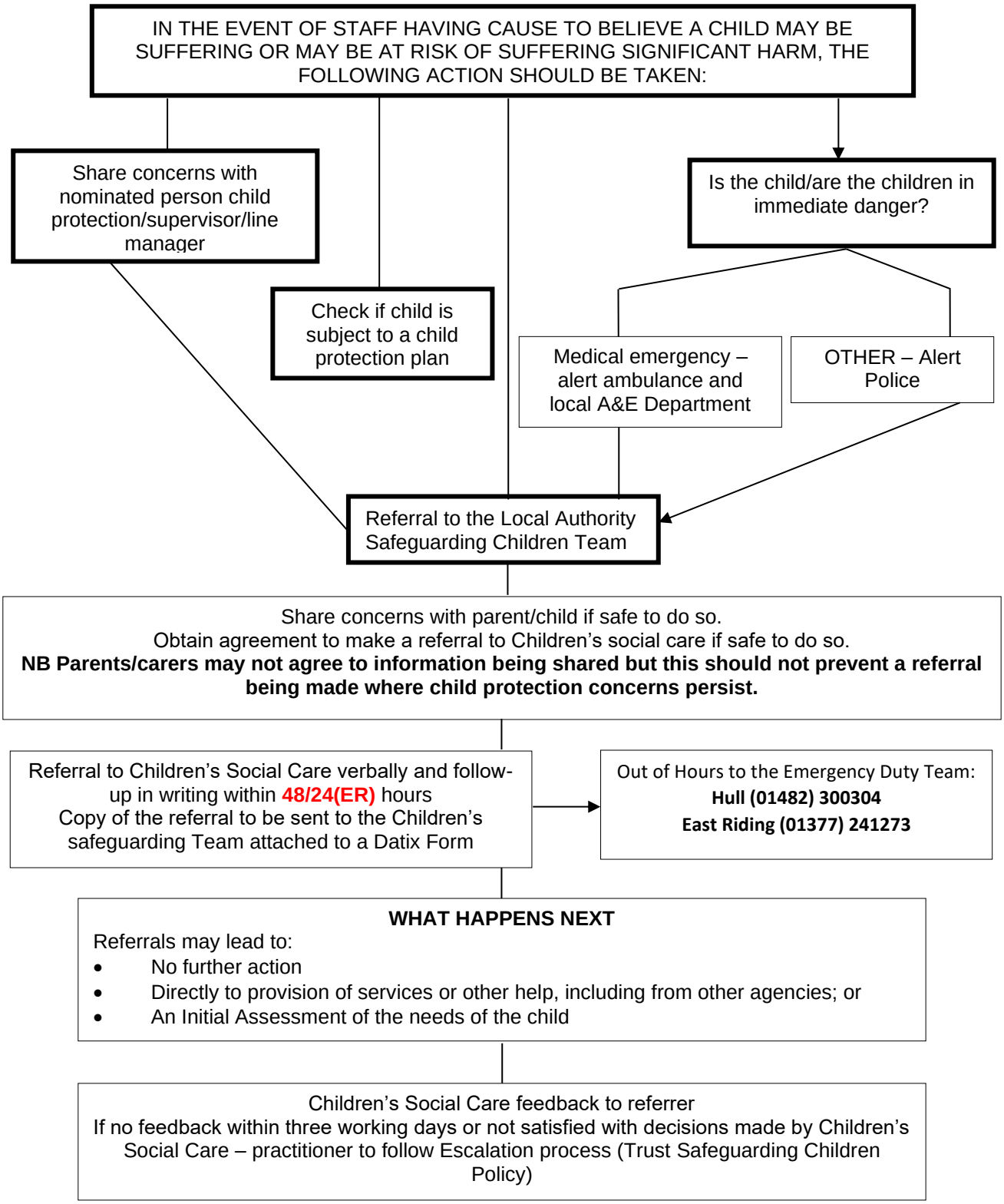
Example Sample Safety Plan (Adult Victims)	
Increasing safety in my relationship	
Where can I keep important phone numbers so that they are always accessible to my children and me?	
The names of two people I can tell about the abuse and ask them to listen out for unusual noises from my home, so that they can call the police if I am being assaulted	**1.** **2.**
What code word or phrase can I use in an emergency to let my children know that I want them to get to safety immediately?	
Four places I can go to if I leave my home:	
Who can I leave extra money, car, keys, clothes and copies of documents with?	
What will I take with me if I leave?	

Where can I leave an emergency bag?	
Where can I hide emergency money and important documents?	
What parts of the house should I avoid when the abuse starts? Where is there no exit? Where are there things that can be used as weapons?	
Increasing safety when a relationship is over	
<u>Things that I might need to do straight away</u> • Change locks, get smoke detectors, get a security system • Get stronger (metal) doors • Get an outdoor lighting system • Change landline and mobile numbers Who will I tell that my partner no longer lives with me?	
Who will I ask to call the police if they see my partner near my home or children?	
I will tell the people who care for my child, who is allowed to pick them up. The people I have given permission to are:	
Who can I tell about my situation at work and ask them to screen my calls?	
What shops, banks and other places that I used to use with my partner do I need to contact?	
Who can I call if I'm feeling down and am tempted to return to my partner?	
Important phone numbers - **Always dial 141 before calling out, so that your number can't be traced**	
Local Domestic Abuse service Refuge	

Example Safety Plan Child/Young Person **This plan records how to keep …… safe**	
The safety plan should not be kept by the child	.
Professionals should not give the child any written material except telephone numbers	
The child needs to rehearse this safety plan with you as part of safety planning intervention	
You have a right to be safe and cared for in safe place	agree
Violent words and actions at home are not your fault	agree
You cannot stop the abuse	agree
My Name and Age (and names and ages of brothers and sisters My Address: My Phone Number:	
Someone I trust and can talk to about my worries is: His/Her Phone Number is: His/Her Address is:	
I have told a friend about the domestic abuse and we have agreed on a code word in case of emergencies	**Code word** -
In the event of an incident	
To be safe I can do things: Get out of the room where the abuse is occurring The room/place in my house where I feel safe is: There is a lock on the door	
Safe places for me to go outside of my home	
If it is safe I can telephone **999**, ask for the police. I will need to say	**My name** **My home address**
If I am hurt I will tell (including telephone numbers) If my mum is hurt I will tell (include telephone numbers)	
If we leave the house I would like to go to I have a bag of things that are important to me at a (safe relative/ friends house)	
The people who know this plan are:	
Other people I can ring in an emergency (include name and phone numbers): They will call for help for me. They know my address and phone number	

Appendix 8 - Action Flowchart

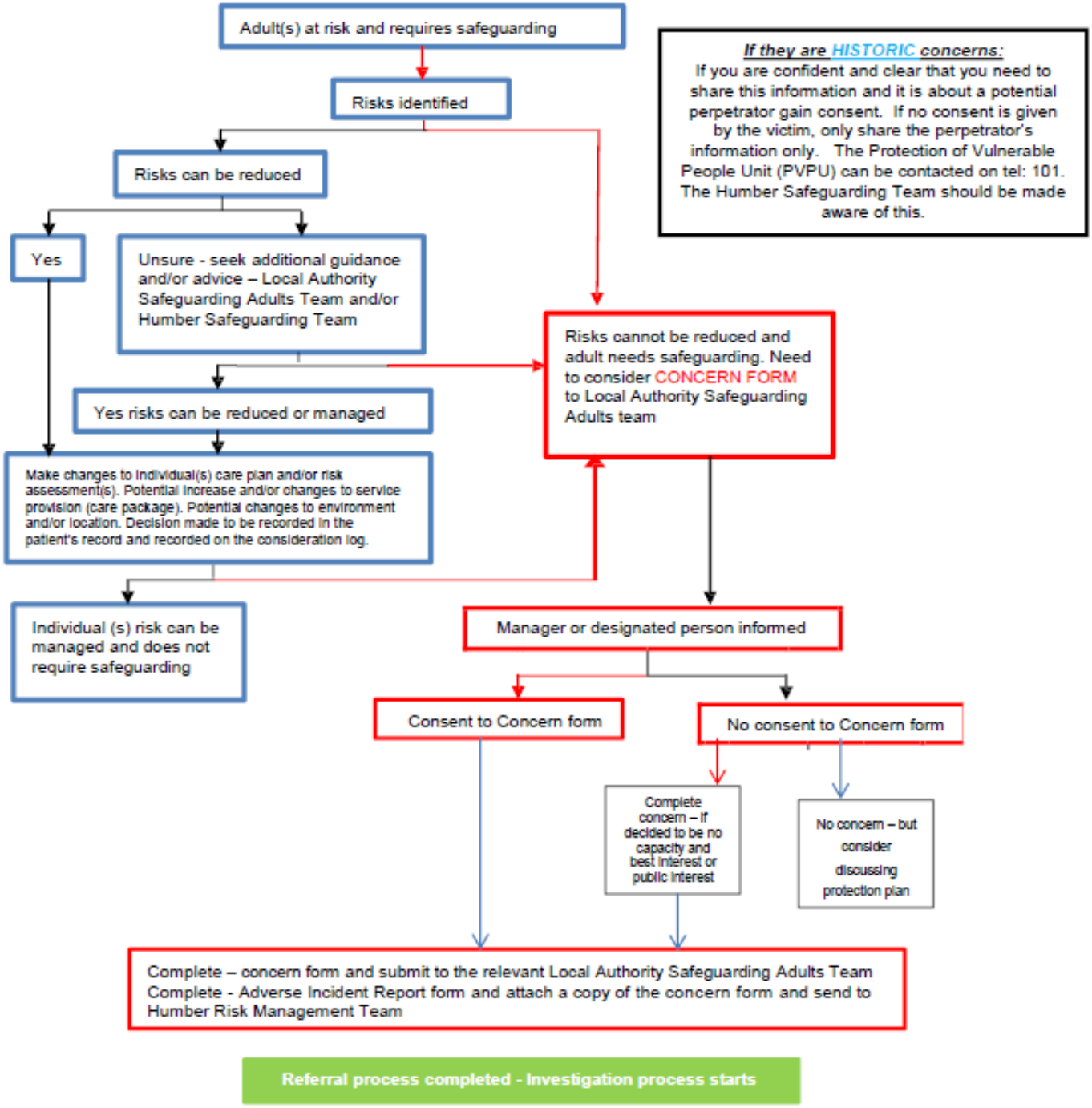
ACTION REQUIRED TO SAFEGUARD AND PROMOTE A CHILD'S WELFARE



Appendix 9 - Adult Referral pathway

Decision Making & Concern Pathway:

There is an adult(s) at risk - institutional, discriminatory, physical, psychological, financial, sexual or neglect. You need to put measures in place to safeguard that adult(s). Consider if the act that puts them at risk was intentional or unintentional or was a failure to act you will need to consider the following:



NOTE: When considering risk you still need to consider the degree & intensity of the harm and/or the potential harm. Risks might be managed and the individual(s) is now safe, but you would still make a referral if the potential harm outweighs the current situation – if unclear seek guidance.

Appendix 10 - MARAC 2 Risk Assessment Conference

CONFIDENTIAL MARAC 2
DOMESTIC ABUSE – MULTI-AGENCY RISK ASSESSMENT CONFERENCE

REFERRAL FORM

DATE OF REFERRAL:	**AGENCY:**
REFERRAL TO MARAC (please specify)	SCHEDULED/EMERGENCY

VICTIM	**PERPETRATOR**
SURNAME	SURNAME
FORENAME(S):	FORENAME(S):
ALIAS:	ALIAS:
DOB:	DOB:
ADDRESS:	ADDRESS:
ETHNIC ORIGIN:	ETHNIC ORIGIN:
RELIGION:	RELIGION:
STATUS OF RELATIONSHIP;	
IF REFUGEE/ASYLUM SEEKER: (victim only) NATIONALITY: STATUS:	
GP DETAILS (victim only):	

VICTIM RISK ASSESSMENT ON REFERRAL;		
STANDARD	MEDIUM	HIGH

CONSENT;	
Service User's Consent obtained? YES/NO	If not, can you satisfy the requirement to share information without consent? YES/NO

LIST ANY CHILDREN;					
NAME	DOB	CHILDREN'S ADDRESS	Relationship to: Victim	Perpetrator	SCHOOL

ADDITIONAL CHILDRENS INFORMATION;
Please provide any relevant details regarding the children e.g. GP details

ADDITIONAL INFORMATION;
E.G Why are your referring case to MARAC and what do want from the process?
REFERRAL TO MAPPA; Yes/No

FROM YOUR PERSONAL KNOWLEDGE OF THE CASE AND/OR YOUR OWN AGENCIES DATABASE PLEASE GIVE DETAILS BELOW OF OTHER AGENCIES/ INDIVIDUALS THAT HAVE BEEN INVOLVED AND YOU FEEL SHOULD BE INVITED TO THE MARAC.

AGENCY	**INDIVIDUAL/ CASE WORKER**	**CONTACT DETAILS Tel no, e mail.**	**FOR COORDINATORS:** ***SIGNED UP TO DV INFO SHARING PROTOCOL Y/N***

Appendix 11 - Forced Marriage, Honour Based Abuse and FGM

FORCED MARRIAGE

Figures released by the Forced Marriage Unit (FMU) show a welcome increase in the number of people willing to come forward to seek protection from forced marriage. However, the true scale of the problem remains unclear. The very nature of forced marriage means that it is likely that a number of cases go unreported.

In conjunction with the policy, reference should be made to the Home Office and The Foreign and Commonwealth Office Forced Marriage Statutory Guidance. In respect of a referral pathway for young people facing forced marriage the advice and guidance should be used with local Safeguarding Children Partnership's Procedures and Guidance.

In 2004, the government's definition of domestic abuse was extended to include acts perpetrated by extended family members as well as intimate partners. Consequently, acts such as forced marriage and 'honour' crimes (which can include abduction and homicide) now come under the definition of domestic abuse. The Forced Marriage (Civil Protection) Act 2007 came into force on 25 November 2008 and provides civil protection for people threatened with forced marriage. This Act will give family courts the power to issue Forced Marriage Protection Orders to prevent someone from forcing another person into marriage. This Act sends out a clear message that forced marriage will not be tolerated.

A clear distinction must be made between a forced marriage and an arranged marriage. In an **arranged marriage**, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangements remains with the people who are to marry. In a **forced marriage**, one or both spouses do not consent to the marriage and some element of duress is involved. It is also important to note that in some forced marriage cases, child trafficking is prevalent. For information and guidance on child trafficking please refer to the Safeguarding Children Policy and Procedure.

HONOUR-BASED VIOLENCE (HBV)

Honour Based Violence (HBV) is a crime or incident which has or may have been committed to protect or defend the so-called 'honour' of a family and community, ultimately the 'crime' will often result in murder. It is a fundamental abuse of human rights. It is a collection of practices used to control behaviour within families, protecting perceived cultural beliefs and so-called 'honour'.

HBV predominantly occurs against women when it is perceived that the woman has acted immorally, which is deemed to breach the honour code of a family or community, causing shame.

If a person does not consent or lacks capacity to consent to a marriage, that marriage must be viewed as a forced marriage whatever the reason for the marriage taking place. Capacity to consent can be assessed and tested but is time and decision-specific.

One Chance Rule

All professionals working with suspected or actual victims of forced marriage and honour-based violence need to be aware of the "one chance" rule. That is, they may only have one opportunity to speak to a victim or potential victim and may possibly only have one chance to save a life. As a result, all professionals working within statutory agencies need to be aware of their responsibilities and obligations when they are faced with forced marriage cases. If the victim is allowed to leave without the appropriate support and advice being offered, that one chance might be wasted.

First steps in all cases:

- See them immediately in a secure and private place where the conversation cannot be overheard
- See them on their own – even if they attend with others
- Explain all the options to them
- Recognise and respect their wishes
- Perform a risk assessment – the DASH assessment tool is advocated for use within this policy
- Contact a trained specialist (forced marriage specialist) as soon as possible
- If the young person is under 18 years of age, refer them to the named person responsible for safeguarding children and activate local safeguarding procedures
- If the person is an adult with support needs, refer them to the named person responsible for safeguarding adults and activate local safeguarding procedures
- If an adult considered to have capacity discloses to an NHS professional that they are in a FM situation, and states that they don't want any further action taken about it, their rights as a patient would need to be respected and patient confidentiality maintained, no reports or referrals made etc. This is the case for rape and domestic abuse too
- Reassure the victim about confidentiality where appropriate, i.e. practitioners will not inform their family
- Establish and agree an effective method of contacting the victim discreetly in the future, possibly using a code word to confirm identity
- Obtain full contact details that can be forwarded to a trained specialist
- Where appropriate, consider the need for immediate protection and placement away from the family

(HM Government 2014)

FEMALE GENITAL MUTILATION (FGM)

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, UNICEF, UNFPA, 1997). It is illegal in the UK to subject a child to female genital mutilation or to take a child abroad to undergo FGM. In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act (2003) and in Scotland under the Prohibition of FGM (Scotland) Act (2005).

Section 74 of the Serious Crime Act (2015) amended the Female Genital Mutilation Act (2003) to introduce the legal duty for regulated health and social care professionals and teachers to make a report to the police if:

- they are informed by a girl under the age of 18 that she has undergone an act of FGM

or

- they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

Advice regarding the mandatory reporting procedure can be found in Appendix 10 and here.

There is an estimated prevalence rate of 7.7 per 1,000 women who are living with FGM and this figure is increasing. An estimated 103,000 women aged 15-49 with FGM born in countries in which it is practiced were living in England and Wales in 2011, compared with the estimated 66,000 in 2001 (Macfarlane and Dorkenoo 2015).

Types of FGM

Type 1: Circumcision	Excision of the prepuce with or without excision of part or the entire clitoris.
Type 2: Excision (Clitoridectomy)	Excision of the clitoris with partial or total excision of the labia minora. After the healing process has taken place, scar tissue forms to cover the upper part of the vulva region.
Type 3: Infibualtion (Pharaonic Circumcision)	This is the most severe form of FGM. Infibulation often (but not always) involved the complete removal of the clitoris.
Type 4	This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Indications that FGM may be about to take place include:

- The family are from a community that is known to practice FGM
- The child may talk about a long holiday to her country of origin or another country where the practice is prevalent
- A child may confide to a professional that she is to have a ‘special procedure’
- Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family
- Any female child who has a sister who has already undergone FGM must be considered at risk, as must other female children in the extended family

RESPONSE AND ACTION TO FEMALE GENITAL MUTILATION

Professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl/woman who has been subjected to FGM however, all Trust staff are required to follow the required process if FGM is identified. After childbirth, a girl/woman who has been de-infibulated may request re-infibulation. This is illegal and should be treated as a child protection concern, as the girl/woman's apparent reluctance to comply with UK law and/or consider that the process is harmful raises concerns in relation to female children she may already have or may have in the future. If any information emerges or concerns that a child under the age of 18 years old is at immediate risk, or has undergone FGM, the mandatory reporting process must be followed.

Professionals should consult with the Trust Safeguarding Team/Local Authority if guidance is required.

Appendix 12 - Clare's Law

The Domestic Violence Disclosure Scheme (DVDS) – often referred to as "Clare's Law" after the case of Clare Wood, who was murdered by her former partner in Greater Manchester in 2009 – was rolled out across all 43 police forces in England and Wales in March 2014 following the successful completion of a 14-month pilot. The Domestic Violence Disclosure Scheme has two functions:

- 'right to ask' – this enables someone to ask the police about a partner's previous history of domestic violence or violent acts. A precedent for such a scheme exists with the Child Sex Offender Disclosure Scheme; and
- 'right to know' – police can proactively disclose information in prescribed circumstances

More information relating to the Domestic Violence Disclosure Scheme can be found here.

Appendix 13 - Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: SAFEGUARDING DOMESTIC VIOLENCE AND ABUSE POLICY (N-054)

2. EIA Reviewer (name, job title, base and contact details): Kerry Boughen, Named Nurse for Safeguarding Children

3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	Individuals will be treated equally regardless of age.
Disability	Where the impairment has a substantial and long-term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	Individuals will be treated equally regardless of needs.
Sex	Men/Male Women/Female	Low	Individuals will be treated equally regardless of gender.
Marriage/Civil Partnership		Low	There is no negative or positive impact due to individual's marriage/civil partnership arrangements
Pregnancy/ Maternity		Low	There is no negative or positive impact due to pregnancy or maternity circumstances

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Race	Colour Nationality Ethnic/national origins	Low	Individuals will be treated in equally regardless of race, ethnicity, culture or nationality.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	There is no impact on the faith groups
Sexual Orientation	Lesbian Gay men Bisexual	Low	There is no negative or positive impact because of sexual orientation.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	There is no negative or positive impact because of gender reassignment processes.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. This policy and other associated guidance for the management of allegations against staff is applied equally to all victims and perpetrators. Abuse can be a concern for anyone therefore the approach to identifying, reporting on and management should remain consistent and comparable across all groups.	
EIA Reviewer: Kerry Boughen	
Date completed: 11/09/2024	Signature: K Boughen

Appendix 14 - Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Policy		
Document Purpose	To provide information and guidance relating to domestic violence and abuse.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates		Community and Primary Care Division Managers, Clinical Managers	
		Children's and Learning Disability Services Division Managers, Clinical Managers	
		Secure Services Division Managers, Clinical Managers	
		Mental Health Services Division Managers, Clinical Managers	
		Domestic Abuse Champions	
		Trust Safeguarding Team	
		Trust Safeguarding Learning and Development Forum	
		Named Doctor Safeguarding Children	
Approving Committee:	Quality and Patient Safety Group	Date of Approval:	11 September 2024
Ratified at:	N/A	Date of Ratification:	Minor amends
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	If applicable	Financial Resource Impact	If applicable
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	This guidance will be discussed within the mandatory safeguarding training programme, through briefings and updates to clinical teams and through safeguarding children supervision. It will be available on the intranet and will link to the Local Safeguarding Children Partnership procedures and guidance.		
Monitoring and Compliance:	Information regarding monitoring and compliance with this policy will be included in quarterly performance reports from the Safeguarding Team to the Trust Quality & Patient Safety Group and the Trust Safeguarding Forum. This will include: • Any new or ongoing domestic homicide reviews; • Quality of and any risk areas associated with MARAC; • Any relevant audits undertaken within the time period; • Impact of new guidance and legislation relating to domestic abuse.		

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
1.01	*Review*	*Dec 2010*	
1.02	*Review*	*4/2/13*	*Reviewed and amended Section 2 additional information regarding new definitions of domestic abuse and abuse. Section 22 additional paragraph added Section 27 and Appendix 2 changes to telephone contact numbers*
1.03	*Review*	*June 2017*	*Reviewed and amended entire document, reclassified as policy.*
1.04	*Review*	*January 2020*	*Policy reviewed. Data and statistics updated. Local safeguarding partnership terms updated.*
1.05	*Review and update - legislation*	*September 2021*	*Reviewed and amended entire document in line with the introduction of the Domestic Abuse Act 2021.*
1.06	*Review*	*September 2024*	*Reviewed. Minor inclusion of suicide risk associated with domestic abuse and inclusion of family members. Guidance for managers removed as its now a standalone document, reference made to it instead. Links checked and updated throughout, where no longer working. Approved at Quality and Patient Safety Group (11 September 2024).*