**Duke Street Surgery**

**DOMESTIC AbusePOLICY**

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**This document was correct at the date of publication. It is the responsibility of the GP practice to check the contents and ensure that they are updated as necessary in accordance with national and local guidance.**

This sample Domestic Abuse Policy is based on national and local safeguarding Children and Adult policies and procedures and the Domestic Abuse Act 2021.It will support GP Practices in promoting the wellbeing of vulnerable children and adults who may be at risk and have difficulty in protecting themselves from harm and abuse.

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**1. INTRODUCTION**

Duke Street Surgeryis committed to support staff within Primary Care to identify and respond to domestic abuse appropriately and safely.

Domestic abuse is a complex issue and can occur within any relationship i.e. same sex, heterosexual and familial. Moreover it is essential that all staff recognise that domestic abuse can be perpetrated by both men and women of all ages and within any community, there are no social or economic barriers.

The Crime Survey for England and Wales year ending March 2020 estimates that 7.3% of women (1.6 million) and 3.6% of men (750, 000) experienced domestic abuse inthe past year

Domestic abuse rarely exists in isolationand is a violation of Human Rights. **The Domestic Abuse Act 2021** states that children who witness domestic abuse are recognised as victims of domestic abuse in their own right. The impact of living with domestic abuse has detrimental emotional and psychological effects on children and it is also a potential indicator for other forms of harm. It is closely associated with substance misuse, homelessness, mental health and some complex medical needs. Being anadult or child victim of domestic abuse can have a major negative impact upon a person’s physical and psychologic health and general wellbeing so should be considered as a major health issue.

**GP Practices should not just focus on domestic abuse as a separate issue or just focus on physical injuries but be aware of the relationship between such abuse upon a person’s general wellbeing and understand the adverse effects of trauma upon health.**

**1.1 SCOPE**

The aim of this policy is to ensure that throughout the work of [Insert name of practice] we will safeguard and promote the welfare of children and adults at risk of domestic abuse. We aim to do this by ensuring that we comply with statutory and local guidance in relation to domestic abuse.

Duke Street Surgeryis committed to implementing this policy and procedures it sets out. The practice will provide learning opportunities and make provision for appropriate domestic abuse training to all staff and partners. This policy will be made widely accessible to staff and partners and reviewed on [Insert date: suggest no later than two years from date of ratification].

This policy addresses the responsibilities of all partners and practice employees and those with whom we have arrangements and should be read in conjunction with the Sample Children and Adults safeguarding policies that incorporate the relevant legislation that underpins the protection of children and adults at risk of harm. It is the responsibility of the Practice Manager and the Practice Lead for safeguarding, to brief the staff and partners on their responsibilities under this policy.

**1.2 Principles**

Duke Street Surgery recognise that safeguarding children and adults at risk of domestic abuse is a shared responsibility with the need for effective joint working between agencies and professionals, with acknowledgement of different roles and expertise if children and adultsare to be protected from harm. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

* The commitment of all staff to ensure a consistent and systematic response to domestic abuse.
* Clear lines of accountability within the practice for domesticabuse.
* Staff training and continuing professional development so that all staff understand their roles and responsibilities, and those of other professionals and organisations in relation to domestic abuse.
* Safe working practices including recruitment and vetting procedures.
* Effective multi-agency working, identifying a lead professional for complex cases to ensure co-ordination of information and ensuring the victims safety.
* Effective information sharing across agencies to ensure all agencies and professionals involved with the perpetrator and victim can contribute to a robust risk assessment.

**2.0 Definition and Types of Domestic Abuse**

The Domestic Abuse Act 2021 was passed in Law in April 2021. The Act created a new cross government statutory definition of Domestic Abuse:

**Domestic Abuse is now defined as:**

Behaviour of a person towards another person is “domestic abuse” if the persons are aged 16 or over and are personally connected to each other. Behaviour is abusive if it consists of any of the following:

Physical or sexual abuse

Violent or threatening behaviour

Controlling or coercive behaviour

Economic abuse

Psychological, emotional or other abuse

Issues related to so called “Honour” Based Abuse, Forced Marriage and Female Genital Mutilation, Stalking and Harassment also fit under the umbrella of domestic abuse and victims are not confined to specific genders or ethnic groups.

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

Domestic Abuse is often driven by the desire of one person to have power and control over another person. This is what is termed as Intimate Terrorism - domestic abuse that includes control and coercion with the victim living in fear of the perpetrator. However research also shows that there can be differences in the driver and causes and desired objectives of the perpetrator of domestic abuse. Situational Couple Violence is where there is no dynamic of power, control and fear but there is conflict and arguments which may lead to emotional and physical violence and involves both partners. Violent Resistance is reactive violence where the victim can become the perpetrator. It is not the same as self-defence. In all 3 types there is a risk of escalation and serious physical and psychological impacts.The focus of support should be on identification and management of risks.

Abuse that exists within interpersonal relationships can encompass, but is not limited to:

**Physical**- Shaking, smacking, punching, kicking, presence of finger or bite marks, starving, tying up, stabbing, suffocation,non-fatal strangulation,throwing things, using objects as weapons, female genital mutilation“honour-based violence”.

Physical effects are often in areas of the body that are covered and hidden (e.g. breasts and abdomen).

**Sexual** - Sexual abuse includes a wide range of behaviours. A partner may be forced to have sex or perform certain kinds of sexual acts against their will. Other kinds of sexual abuse include denial of contraception, sexual insults, or being forcibly subjected to pornographic or violent sexual materialor and forced marriage.Sexual abuse alsoincludes sharing or threatening to share intimate images and serious harm resulting from sexual activity even if the activity was thought to be consensual.

**Economic** - Controlling financial resources in a way that blocks the victim’s access to them when needed. It may include gambling, denying access to money or credit cards; refusing to pay bills; denying food, clothing, mobile phones and claiming welfare benefits and access to transportation. Having sole control over finances and property, damaging property and preventing access to education and employment. This type of abuse is designed to limit someone’s freedom.

**Psychologicaland Emotional** - includes systematic verbal humiliation, insulting, criticism and/or intimidating threats aimed directly at the partner or at what is precious to the partner; this may include children or pets. It may include threats from the perpetrator of suicide or self-harm. It may also present as social abuse where extreme demands for the partner’s time and attention result in the victim’s increasing isolation, for example the partner may be extremely jealous or possessive, accusations of sexual infidelity or emotional disloyalty, sometimes blocking social support or resources.

**2.1 Controlling or Coercive Behaviour**

The Serious Crime Act 2015 ~~i~~ncludes a new offence of coercive or controlling behaviours in intimate or familial relationships, which also fits under the umbrella of Domestic Abuse (HM 2015).

**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. Controlling or coercive behaviour does not only happen in the home, the victim may be monitored by phone or social media from a distance and can be made to fear violence.

**Coercive behaviouris**: 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.'

**2.2Types of Controlling and Coercive Behaviour:**

The types of behaviour associated with coercion or control are:

* Isolating a person from their friends and family.
* Depriving them of their basic needs.
* Monitoring their time.
* Monitoring a person via online communication tools or using spyware.
* Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep.
* Depriving them of access to support services, such as specialist support or medical services.
* Repeatedly putting them down such as telling them they are worthless.
* Enforcing rules and activity which humiliate, degrade or dehumanize the victim.
* Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities.
* Financial abuse including control of finances, such as only allowing a person a punitive allowance.
* Threats to hurt or kill (threats to kill should always be taken seriously and acted upon, raising a safeguarding alert and informing the police).
* Threats to a child.
* Threats to reveal or publish private information (e.g. threatening to ‘out’ someone).
* Assault.
* Criminal damage (such as destruction of household goods).
* Rape.
* Preventing a person from having access to transport or from working.

(This is not an exhaustive list)

 **2.3 Familial Domestic Abuse**

**Domestic abuse is not just confined to intimate relationships but can also occur between family members. It is important to recognise domestic abuse between family members and afford supportive responses and risk reduction**

**Adolescent to parent abuse:**

Adolescent to parent abusecan be a complex dynamic.It is important to understand the pattern of behaviour within the family unit. There may be a history of or present domestic abuse between the adults in the family home. There may be other siblings at risk of abuse from the young person using harmful behaviours. There are many factors which can contribute and or exacerbateadolescent to parent abuse, such as the young person being subjected to bullying, being a victim of exploitation, substance or alcohol misuse, suffering mental ill health or having witnessed domestic abuse within the family. In some cases there are no contributing factors evident. Although it may be beneficial for some parents to develop parenting strategies this issue should never be thought of as merely a parenting issue.

The victim parent may find it difficult to disclose this abuse for fear of criminalising the young person, self-blame and shame. Parents who experience this type of abuse need specialist support related to safety plans, supporting the child using harmful behaviours, addressing their own and the health needs of the young person using harmful behaviours and protection of other family members such as siblings.

Adolescent to parent abusecan be serious and risk canescalate,it is important that risk is identified and managed. Referrals to domestic abuse services can be made to support the victim and a referral to children’s social care requesting support for the family is essential for the welfare of the child and safety for the victim.

Further guidance can be found in the Home Office Guidance:

[Information guide: adolescent to parent violence (safelives.org.uk)](https://safelives.org.uk/sites/default/files/resources/HO%20Information%20APVA.pdf)

**Adult Child to Parent Abuse:**

Adult Child to Parent abuse is also a potentially serious form of domestic abuse which can escalate in risk. There may also be added complexities due to the parent/child dynamic and victims may find it more difficult to disclose this type of abuse. It is important that Primary Care is aware of this type of domestic abuse and respond according to risk.

**2.4So Called Honour Based Abuse**

The Crown Prosecution Service definition ofso-called Honour Based Abuse (2018) iscrime or incident which has or may have been committed to protect or defend the honour of the family and/community.” There is no specific offence of “honour-based abuse” but it is an umbrella term used to encompass various offences covered by present legislation for example Forced Marriage and Female Genital Mutilation.So called Honour Based Abuse can be described as a collection of practices which are used to control behaviour within the family or cultural groups to protect the honour code of the family or cultural group.

The Police andDomestic Abuse Services can support victims of so-calledhonour-based abuse.The Police have a dedicated team that aims to protect victims. Police should be contacted via telephone 101 or telephone 999 in an emergency.

**2.5 Forced Marriage**

There is a clear distinction between a forced marriage and an arranged marriage; everyone should have [the right to choose](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf). In arranged marriages, the families of both spouses take a leading role in arranging the marriage, but the choice of whether or not to accept the arrangement still remains with the prospective spouses. However, in forced marriage, one or both spouses do not consent to the marriage but are coerced into it. Duress can include physical, psychological, economic, sexual and emotional pressure. In the cases of some vulnerable adults who lack the capacity to consent, coercion is not required for a marriage to be forced.

The UK Government regards forced marriage as an abuse of human rights and a form of domestic abuse, and where it affects children and young people, child abuse. Forced Marriage is a criminal offence. It can happen to both women and men, although many of the reported cases involve young women and girls aged between 16 and 25. There is no “typical” victim of forced marriage; some may be over or under 18 years of age, some may have a disability, some may have young children and some may also be spouses from overseas.

If a person lacks Mental Capacity they cannot consent to marriage and it is unlawful to consent to marriage on behalf of another person therefore if a person is deemed to lack mental capacity and a marriage is to take place or has taken place that should be responded to as a safeguarding issue

**2.6 Responding to Forced Marriage in Primary Care**

Any discussion and agreement-seeking with the victim’s family or community may increase the risk to the victim due to the association with ‘family honour’ and so-called honour-based violence and abuse. All professionals working with suspected or actual victims of forced marriage and so called honour-based abuse need to be aware of the [“one chance”](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf) 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 Duke Street Surgeryneed to be aware of their responsibilities and obligations when they are faced with forced marriage cases. If the victim is allowed to leave the practice without the appropriate support and advice being offered, that one chance may be lost.

The victim’s safety is paramount if they report forced marriage and a referral to the police and adult safeguarding should always be considered. For victims less than 18 years old a referral to children’s social care must be completed. In an emergency you should call 999 if you are worried an adult or child is at immediate risk of harm. If not at immediate risk,contact the police directly telephone 101. Adult and children safeguarding procedures must also be followed. Family/friends must never be used as interpreters and records must be kept strictly confidential

**2.7Forced Marriage Unit**

The Forced Marriage Unit (FMU) is a joint Foreign and Commonwealth Office and Home Office unit was which set up in January 2005 to lead on the Government’s forced marriage policy, outreach and casework. It operates both inside the UK, where support is provided to any individual, and overseas, where consular assistance is provided to British nationals, including dual nationals.

The FMU operates a [public helpline](https://www.gov.uk/stop-forced-marriage) to provide advice and support to victims of forced marriage as well as to professionals dealing with cases. The assistance provided ranges from simple safety advice, through to aiding a victim to prevent their unwanted spouse moving to the UK (‘reluctant sponsor’ cases), and, in extreme circumstances, to rescue victims held against their will overseas.

**If a professional contacts the Forced Marriage Unit due to concerns of Forced Marriage localsafeguardingreferral procedures must also be followed**

**2.8 Female Genital Mutilation**

The World Health Organisation (WHO) states that female genital mutilation (FGM):

“*Comprises of all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons*” ([WHO 2014)](http://www.who.int/mediacentre/factsheets/fs241/en/)

FGM is also known as Female Circumcision (FC) and Female Genital Cutting (FGC). The reason for these alternative definitions is that it is better received in the communities that practice it, who do not see themselves as engaging in mutilation.

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003. It is a serious form of child abuse and violence against women. The FGM Act (2003) makes it unlawful for UK nationals or habitual UK residents to carry out FGM in the UK or abroad, or to aid, abet, counsel or procure the carrying out of FGM even in countries where FGM is legal.

This legislation was designed to prevent families and carers from taking girls abroad to undergo the procedure. The Act increased the maximum penalty for being found guilty of FGM from 5 to 14 years imprisonment. The Female Genital Mutilation Act 2003 also made it a criminal offence to re-infibulate following childbirth.

Section 5B of the 2003 Act 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 or adults at risk under the Care Act 2014which they identify in the course of their professional work to the police. The duty came into force on 31 October 2015

Children Social Care Safeguarding referrals should also be made regarding any under 18-year-old female known to have had FGM.Safeguarding referral to Adult Social Care Safeguarding Team should also be made for an adult at risk as defined under the Care Act 2014 if FGM is known to have occurred.Specialist forensic examination and emotional/psychological support may be required which would be agreed during a Strategy discussion.

‘Known’ cases are those where either a female informs the person that an act of FGM – however described – has been carried out on her, or where the professional observes physical signs on a female appearing to show that an act of FGM has been carried out and the professional has no reason to believe that the act was, or was part of, a surgical operation.

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf>

There is no mandatory duty to report actual known historical FGM in adults over age 18 years (unless classed as an adult at risk under the Care Act 2014)to the police. Medical/psychological support may be required. Possible wider issues found within FGM practising communities will need to be explored with a woman, i.e. domestic abuse;honour-basedabuse and forced marriage.

Evidence informs us that girls born to mothers with FGM are also at risk of being subjected to FGM, a child safeguarding referral is therefore required for a multi-agency strategy discussion to assess the risk to any females associated with a woman identified with FGM.The referral to Children Social Care should be made regarding all daughters under age 18 years if a woman is found to have FGM even if the parents state that they do not wish to carry out FGM on their daughters. In many cultures who practice FGM considerable pressure is put upon parents to have FGM performed on their daughters and it is very much linked to the concept of honour.A Strategy meeting is required so that risk can be fully addressed and appropriate safety plans put in place. As part of the strategy meeting a forensic examination may need to take place.

Staff should be aware of high-risk groups when dealing with new clients or transfers into the area and it is advised that clinical staff should attend training on FGM.

The Department of Health guidance Flow Chart can be found in Appendix 2. This shows the procedure to follow regarding referral to the Police and Children Social Care if a young person under 18 years of age or an adult at risk under the Care Act 2014has had FGM or if a young person under 18years/vulnerable adult is at risk of FGM. The flow chart also gives guidance regarding mandatory reporting of FGM to NHS Digital.

From October 2015 GP practices have a mandatory duty under the Health and Social Care Act 2012 to submit data under the FGM Enhanced Dataset information standard (SCC12026). The FGM Enhanced Dataset is part of the FGM Prevention Programme. NHS Digital works with NHS England to manage the data submissions. Data collection is through the NHS Digital Clinical Audit Platform (CAP). GP practices should register to access the CAP at NHS Digital so that they are in a position to submit data promptly should FGM be identified.

Explicit consent to record identifiable data on the dataset is not required as it is required under the direction of the Department of Health. Women and girls should be advised that FGM information will be submitted to the FGM Dataset. Identifiable information will not be published. Further advice regarding Clinical Audit Platform registration and consent can be found on the following link:

<https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/female-genital-mutilation-datasets>

Pathway – Children

Lancashire: [FGM](https://panlancashirescb.proceduresonline.com/pdfs/fgm_path_chld.pdf) Pathway

Cumbria: [Female](https://cumbrialscb.proceduresonline.com/chapters/p_fem_gen_mutil.html) Genital Mutilation

North Yorks: [Female Genital Mutilation](https://www.safeguardingchildren.co.uk/Resources/female-genital-mutilation-fgm/)

**3.0 Roles and Responsibilities in Primary Care**

The Domestic Abuse Act 2021 highlights that the NHS must be able to demonstrate accountability in enquiring, recognising and responding to domestic abuse and that NHS staff should receive appropriate training in relation to domestic abuse.

The NHS is often the first point of contact for victims who have experienced Domestic Abuse. The health service especially Primary Care plays an essential role in responding to helping prevent further Domestic Abuse by intervening early, providing treatment and information and referring patients to specialist services. As highlighted Domestic Abuseis linked to a host of different health outcomes and is a risk factor for a wide range of both immediate and long-term conditions.

Primary care, as part of the wider health economy has a duty to respond to victims of Domestic and Abuse to safeguard adults at risk and their children. This response can improve public health, improve health outcomes and support a patient-centred service and addresses not only the contemporary health burden but also that of future generations.

**4.0 Information Sharing**

Sharing of information is vital for early intervention to ensure that adults and children at risk of domestic abuse receive the support they require for their own safety and the safety of any children involved. It is also essential that all practitioners understand when, why and how they should share information.

Fears about sharing information cannot be allowed to stand in the way of the need to safeguard and promote the welfare of children at risk of abuse or neglect. No practitioner should assume that someone else will pass on information which may be critical to keeping an adult or child safe (HM 2015).

Where there is concern that the adult or child may be suffering or is at risk of suffering significant harm then their safety and welfare **must** be the overriding consideration. Information may also be shared where an adult is at risk of serious harm, or if it would undermine the prevention, detection, or prosecution of a serious crime including where consent might lead to interference with any potential investigation.

For informationsharing refer to [*Information sharing: Guidance for practitioners and managers*](https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice)(HM Government 2018)

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf>

**4.1 Providing Evidence for Domestic Abuse Reports:**

The Domestic Abuse Act 2021 states that:

“No person may charge a fee or any other remuneration for the preparation or provision of relevant evidence relating to an assessment of an individual carried out by a relevant health professional in England and Wales under a qualifying medical contract.” Relevant evidence means:

Evidence that the individual is at risk of being, a victim of domestic abuse which is intended to support an application by the individual for civil legal services or any other evidence that the individual is, or is at risk of being, a victim of domestic abuse. This applies to:

A medical practitioner licensed to practice by the GMC

A health professional registered to practice in the UK by the NMC

A paramedic registered to practice in the UK by the Health and Care Professions Council

**5.0 IDENTIFYING and Recognising Domestic Abuse**

A GP or practice nurse may be the first person to recognise an individual’s health problems or carer related stress issues, or someone whose behaviour may pose a risk to adults or children. The primary health care team may therefore be the first point of contact for victims or perpetrators of domestic abuse. In some cases the adult victim may also have care and support needs and their needs may meet the threshold for assessment and support from Adult Social Care. If an adult victim is not able to protect themselves because of care and support needs then a referral to Social Care Adult Safeguarding team should be made.

Professionals have a duty to refer to children’s services, using local policies and procedures, even if the adult victim chooses not to, or is not able to accept help for themselves when the adult victim has children or is pregnant.

**5.1 Identifying Domestic Abuse**

Often people suffering domestic abuse have unnecessary investigations and medication for nonspecific or mental health symptoms. It is important to recognise patients whose symptoms mean they might be more likely to be experiencing domestic abuse.Consider making a safe enquiry in patients with health markers of domestic abuse. These include:

* + Symptoms of depression, anxiety, PTSD.
	+ Unexplained symptoms/nonspecific symptoms.
	+ Tiredness, sleep disorders.
	+ Chronic unexplained pain, unexplained gastrointestinal symptoms.
	+ Unexplained gynaecological symptoms, sexual dysfunction.
	+ Sexually transmitted infections or unintended pregnancies, terminations.
	+ Self-harm or suicidal tendencies.
	+ Frequent attendance at surgery or A&E.
	+ Delay between injury and presentation.
	+ Injuries inconsistent with the explanation or injuries at different stages of
	+ healing.

[Overview | Domestic violence and abuse | Quality standards | NICE](https://www.nice.org.uk/guidance/qs116)

**5.2Routine Enquiry of Domestic Abuse**

Nice Guidance 2016 highlighted the importance of health professionals using safe routine enquiry into domestic abuse. This is also a recommendation of the Domestic Abuse Bill 2021. National and local Domestic Homicide Reviews have also highlighted that Primary Care should use safe routine enquiry to provide opportunity for victims to make a disclosure and receive appropriate responses and support. It is also recommended from Domestic Homicide Reviews that GP Practices should ask about domestic abuse in Mental Health related consultations. Therefore GP Practices should implement the use of safe routine enquiry.

Safe Routine Enquiry should be made if someone presents with indicators of domestic abuse as listed in section5.1. Routine enquiry into domestic abuse can also be added to health assessments for instance new patient medicals and routine health checks as best practice. This changes the culture and encourages people to make disclosures.

Enquire sensitively and safely; create an opportunity, provide a quiet environment where confidentiality can be assured for the victim to discuss their experience.

Examples of questions to aid disclosure are:

“Do you have a supportive partner? Does your partner ever hurt you verbally, physically or sexually? Does your partner ever try to control what you do or controls you finances?” Does anyone make you feel scared?

**5.3 Safe Enquiry about Domestic Abuse During Telephone Consultations**

*Please note this is being piloted in Pennine area and provided for information*

It’s important to make sure that the patient you are in contact with is alone and safe before speaking with them about abuse. This is particularly the case when supporting them over the phone or online. Ask closed questions to establish this, allowing them to give ‘yes’ or ‘no’ answers. E.g. 'Are you alone?’ 'Is it safe to ask you some questions about your relationship?’

If it is safe to talk to the patient, establish a code word or sentence, which they can say to indicate that it’s no longer safe to talk and end the call. (e.g. 'No I'm not interested, thank you.' In which case you should call back later.) If it isn’t a safe time then ask for a suggested safe time to call back. Be aware that situations change quickly and that risk is dynamic. It is important to always follow up and call back later or ask a colleague to call back if someone terminates a call abruptly.

Be aware that the perpetrator of the abuse may be in the house or enter the house during the consultation, ask the patient to terminate the call if the perpetrator of the abuse comes into the room.

Ask if the patient feels safe and if there is any immediate danger. Always advise calling 999 if there is any immediate danger. If the patient is unable to do this, but wants to, you can offer to do this for them. Remind the patient that if they are in danger they can still access healthcare services despite COVID-19 restrictions.

If the patient does not speak English, ensure that an independent interpreter is available. Do not use family members or friends as translators.

Frame your enquiry by explaining the prevalence of domestic abuse before asking a more direct question. For example: “We routinely ask about domestic abuse because it is so common, affecting approximately 1 in 4 people…”

Validate the patient’s experience with phrases like ‘I believe you’ or ‘this is not your fault.’ A patient will be in an extremely vulnerable situation if self-isolating with the perpetrator of abuse. Ask about what support the patient has and what support they might need.

**RISK ASSESS**Ask the patient if the abuse is getting worse. Ask if the patient feels unsafe to stay in the home/is in immediate danger. If the patient says yes, they feel unsafe to stay in the home/are in immediate danger offer to call the police on 999 and do so if they want you to. Consider whether a safeguarding referral is needed if there are any children and/or vulnerable adults at risk in the home and follow your usual safeguarding procedures.

**REFER/ SIGNPOST** as appropriate to local Domestic Abuse Services:

**BWD WISH Centre–tel: 01254 260465.** You can also make victims/survivors aware of the WISH Centre online support service at [www.thewishcentre.org](http://www.thewishcentre.org/)

**Lancashire Victim Support Domestic Abuse Services–tel: 0300 323 0085**

**Blackpool Fylde Coast Women’s Aid tel: 01253 596699**

**Cumbria Domestic Abuse Services Victim Support–tel:0300 303 0157**

**North Yorkshire -01609 643100**

**RECORD** Make sure you document all enquiries, disclosures and referrals on the patient’s record but in a way to hide it from online access in case a perpetrator is able to access their victim’s record. If a patient requests printed medical records, details of domestic abuse must be redacted. Document any concerns that you have, even if the patient does not disclose domestic abuse.

You might not get a disclosure the first time you ask, victims may respond defensively or dismissively due to fear, or the perpetrator may have entered the room or be listening in. That doesn’t mean there is no abuse, and they may make a disclosure later if you provide those opportunities. Remember to revisit your concerns if you have them.

**5.4 Risk factors for Domestic Abuse**

Summarised below are some of the main risk factors associated with domestic abuse. These are grouped and not exhaustive; a useful acronym to remember some key factors is **S P E C S SSS**(DH 2013).

* **S**eparation/Child Contact: Leaving a violent partner is extremely risky. In London 76% of domestic abuse murder victims had recently ended their relationship.
* **P**regnancy, 30% of domestic violence and abuse starts in pregnancy. One in five teenage victims are pregnant (Safe Lives).
* **E**scalation of violence; previous domestic violence is the most effective indicator that further domestic violence will occur. 35% of households have a second incident within five weeks of the first.
* **C**ultural factors: language barriers, immigration status, isolation, FGM practising community.
* **S**talking: Research finds that intimate relationship stalkers use more dangerous stalking behaviours than non-intimate relationships stalkers.
* **S**exual Assault: Where abusers use both physical and sexual violence, victims are at an elevated risk.
* **S**uicidal ideation: heightened risk
* **S**trangulation/stabbing: most female domestic abuse homicides are caused by strangulation and most male domestic abuse homicides are caused by stabbing

**5.5 Toxic Trio**

Toxic Trio refers to the co-existence of parental substance misuse, mental health problems and domestic abuse. Learning from serious case reviews has highlighted that the combination of these factors is particularly ‘toxic’ and pose risks of harm to children who live in these households (Brandon et al 2012).

**5.6 Impact on Children and Young People**

The Domestic Abuse Act 2021 states that children should be recognised as victims in their own right and not just as witnesses of domestic abuse. Research tells us there is a significant link between abuse to a partner and the abuse of children. 70% of men who are violent to their partner are also violent to the victim’s children whether they are the perpetrators childrenor not. Living with Domestic Abuse has a significant detrimental effect on the well-being and development of children. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children are greatly distressed by witnessing the physical and emotional suffering of a parent. Domestic Abuse is recognised as an Adverse Childhood Experience (ACE).

Children's exposure to parental conflict, even where physical violence is not present, can lead to serious emotional trauma, anxiety and distress which may express itself in different ways. The child may become withdrawn or extraverted. For some children the impact may lead to them becoming involved in anti-social or criminal behaviour. There is potentially a direct risk of physical harm to the child from the perpetrator; this should always be considered in all assessments.

The negative impact of domestic abuse is exacerbated when the abuse is combined with substance misuse as this can increase the severity of the attacks.

Children living with Domestic Abuse are at increased risk of behavioural problems, mental health difficulties in later life and have a higher risk of sexual abuse.

**5.7 Signs displayed by children that may be living with Domestic Abuse**

* They actively disclose information about it.
* Injuries to themselves.
* Anxiety.
* Depression.
* Unexplained illness.
* Constant worry about family members and their safety.
* Insomnia or nightmares.
* Failure to thrive.
* Poor achievement at school, poor attendance.
* Behavioural difficulties, anti-social behaviour, criminal activity.
* Bedwetting.
* Self-harm.
* Speech and language delays.
* Substance misuse.
* Missed health appointments.
* Regularly missing from home

**5.8 Unborn Child**

The unborn child can also be affected by domestic abuse; there is a higher risk of miscarriage, preterm labour, stillbirth and low birth weight.

There is growing evidence that the intrauterine foetal environment can influence foetal development, possibly even having long-term consequences for the child’s development and the development of pathophysiology and health outcomes in adulthood.

Studies have found association between maternal cortisol and altered child outcomes including psychological behavioural problems and higher child cortisol concentrations; early postnatal behaviours may be seen

* Hypervigilance (increased arousal) – ‘being on alert’ high levels of fear and anxiety. This can present in various ways:
	+ Excessive crying.
	+ Failure to thrive.
	+ Sleep disturbance.
	+ Delayed speech and language.
	+ Delay in independent skills such as toileting, dressing and playing alone.
	+ Anger and aggression.

Zijlmans, Riksen-Walraven and Weerth (2015)

**5.9Impact of Domestic Abuse on parenting**

Living with Domestic Abuse does not automatically result in poor parenting; this depends on a range of factors including adverse childhood events for the parent.Consideration of domestic abuse therefore should be present in any assessment undertaken relating to the safety and well-being of a child.

Some parents also misuse drugs or alcohol, experience poor mental health and experience domestic abuse, when these 3 factors co-exist it is known as ‘the toxic trio’ which significantly impacts on parenting capacity. The co-morbidity of these issues compounds the difficulties parents experience in meeting the needs of their children and increases the likelihood that the child will experience abuse and/or neglect.

**5.10Domestic Abuse in older people**

National and local Domestic Homicide Reviews have shown that despite high prevalence there has been a failure to recognise domestic abuse in older people. Domestic Abuse is recognised as a category of abuse under the Care Act 2014.There are potential added barriers to reporting including the victim being dependent on the perpetrator for care, or the perpetrator being dependent on the victim for care. Older people may have traditional attitudes to marriage and gender roles. Older people may have suffered domestic abuse for a very long time which can make it harder for them to seek support. Some people may become more vulnerable to abuse from family members or someone in a relationship of trust as they become older and they may be more isolated. Frailty, dependence on partner, family or trusted carer, and physical or mental illness should not prevent staff from recognising or exploring signs of domestic abuse. Staff must be vigilant of signs of domestic abuse (or other types of abuse) when working with older people. Staff should not accept or ignore signs of abuse that may be covered up by other factors such as mental illness or dementia. These factors should not just be accepted as medical and risk must not be minimised, the safety of the victim should be prioritised. Also staff must be aware that an older person may be a perpetrator of domestic abuse and risk should not be minimised due to that perpetrator appearing frail or vulnerable themselves. Victims should be signposted or referred to the local Domestic Abuse service for risk assessment and safety planning. Any threats to harm the victim must be taken seriously. With older victims there are potential complex issues that may need to be addressed by a multi-agency team of professionals. When an older victim is suffering domestic abuse making a Safeguarding referral to Adult Social Care should be considered.

**5.11Male Victims**

Although the majority of known victims are female it is important to understand that males can also be victims of domestic abuse. Health staff should be aware that male victims are often more reluctant to disclose due to perceived stigma, less public awareness and fewer support options being available. Staff should give opportunity for males to disclose domestic abuse in the same way that they would with females and it is just as important to identify and manage risk with male victims. Male victims will be offered support from domestic abuse services and there is also some safe housing provision and available accommodation for maleswith or without children

**5.12Lesbian Gay Bi Sexual and Transgender + Groups (LGBT+)**

It is known that 1:4 lesbian and bi sexual women and 1:3 gay and bisexual men suffer domestic abuse at some point in their life. It is known that people from these groups are reluctant to report domestic abuse due to perceived prejudice and lack of dedicated support services. Staff should give opportunity for people from LGBT + groups to disclose domestic abuse in the same way that they would with people from other groups. Domestic Abuse support services will offer support and it is just as important to address risk.

**5.13Domestic abuse in teenage interpersonal relationships**

Research shows that many young people experience Domestic Abuse in their own intimate relationships (NSPCC & Bristol University 2009) and young people exposed to domestic abusein childhood are more likely to experience abuse in their own relationships. Teenage relationships are often short lived but can be just as intense as adult relationships and real danger may be present if the relationship is abusive. All practitioners who work with young people, including looked after children (LAC) should safely enquire about abuse in intimate peer relationships, as young people are unlikely to disclose it spontaneously.Domestic abuse services will offer support to young people experiencing domestic abuse in their own intimate partner relationship. Identification of risk and risk management is important and can be completed by specialist domestic abuse services. Under 18-year-olds experiencing domestic abuse in their own intimate relationship may need to be referred into Children Social Care for assessment of risk

**6.0 Responding to Domestic Abuse**

If a disclosure of domestic abuse is made it is important that a safe response is given. Focus on safety and assess the immediate safety of the victim and any children. Remember to use a trauma informed approach as the way in which you respond to the victim will have a major impact, validate the victim disclosure. If the victim is in immediate danger call the Police telephone 999.

Practice Staff should be familiar with local Domestic Abuse Services and signpost or refer the victim as appropriate. The Domestic Abuse Services can support victims and children and offer further risk assessment and safety planning.

Commissioned Domestic Abuse Services across Lancashire, South Cumbria and North Yorkshire are:

* **BWD WISH Centre –tel: 01254 260465.**
* **Lancashire Victim Support Domestic Abuse Services –tel: 0300 323 0085**
* **Blackpool Fylde Coast Women’s Aid tel: 01253 596699**
* **Cumbria Domestic Abuse Services Victim Support –tel:0300 303 0157**
* **North Yorkshire - 01609 643100**

You can find further information on responding to domestic abuse in the RCGP Toolkit:

<https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit.aspx>

Consult with your Safeguarding Lead/ Manager and consider the completion of a [SafeLives DASH Risk Indicator Checklist](http://panlancashirescb.proceduresonline.com/pdfs/caada_risk_ind_checklist.pdf)if trained to use this.

The Safe Lives Risk Indicator Checklist is a researched tool used to assess risk in domestic abuse situations. This can be used at disclosure with victims from the age of 16years and if the checklist identifies that the victim is high risk of serious injury or murder a referral to MARAC (Multi Agency Risk Assessment Conference) should be made. At this point immediate safety should be put in place and if there are children in the household a safeguarding referral to Children Social Care should be made. If the victim is an adult at risk under the Care Act 2014referrals should also be made to Safeguarding Adult’s Social Care. If using the risk indicator checklist it is important that GP practices are familiar with the referral process into MARAC as safety of the victim and children needs to be addressed. (Please consult the Safeguarding Team if further advice is needed). If the GP Practice is not trained in using the risk assessment checklist the service user can be referred to IDVA (Independent Domestic Violence Advocate) who will complete the risk assessment checklist.

**NB:**Any concerns regarding immediate riskto victims and children or threats to kill should be reported to the police. Telephone 999

Children Safeguarding issues must be referred to Children Social Care and Adults at Risk referred to Adult Social Care

**6.1 Role of the Independent Domestic Violence Advisors (IDVAs)**

IDVAs help keep victims and their children safe from harm from violent partners or family.

Serving as a victim’s primary point of contact, IDVAs normally work with their clients from the point of crisis, to assess the level of risk. They:

* Discuss the range of suitable options.
* Develop plans for immediate safety – including practical steps for victims to protect themselves and their children.
* Develop plans for longer-term safety.
* Represent their clients at the MARAC.
* Help apply sanctions and remedies available through the criminal and civil courts, including housing options.

These plans address immediate safety, including practical steps for victims to protect themselves and their children, as well as longer-term solutions. Referrals for an IDVA can be made via your local Domestic Abuse Services

**6.2 Multi Agency Risk Assessment Conference(MARAC)**

A MARAC is a multi-agency meeting, which has the safety of high-risk victimsof domestic abuse and their children as its focus. The MARAC is a risk focused process involving the participation of all the key statutory and voluntary agencies who might be involved in supporting victims of domestic abuse. The objective of the MARAC is to share relevant and proportionate information and establish a co-ordinated safety plan to support the victim and make links with other public protection procedures, particularly the management of offenders, safeguarding children, and adults at risk.

The MARAC meeting is a part of a wider process which hinges on the early involvement and support for victims from an Independent Domestic Violence Advisor (IDVA) and continued specialist case management, both before and after the meeting.

In some localities Multi Agency Risk Reduction Assessment Coordination Teams have been set up to replace the traditional MARAC model.  These teams have the same objective as the traditional MARAC model but work with the victims, children and perpetrators from the point of referral.

**6.3 Domestic Abuse Disclosure Scheme** [(DVDS)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf)**or Clare’s Law - Implemented across England and Wales from March 2014**

**Right to ask**

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

GP Practices can advise victims to make an application to the police if appropriate via telephone 101.

**Right to know**

This enables an agency (including health) to apply for a disclosure if the agency believes that an individual is at risk of domestic violence from their partner. Again, the police can release information if it is lawful, necessary and proportionate to do so.Applications can be made to the Police via telephone 101. The practice would not inform the victim or perpetrator that the application was being made.

**6.4 Domestic Abuse Protection Notices and Orders:**

Domestic violence protection orders and notices (DVPN/DVPO) were implemented across England and Wales in 2014. The Domestic Abuse Act 2021 will now replace the DVPN and DVPO’s with the Domestic Abuse Protection Notices/Orders (DAPN/DAPO). These will enable the protection of victims from all forms of domestic abuse, including non-physical abuse and controlling or coercive behaviour.DAPN will give victims immediate protection following an incident. DAPN will be issued by the police and can require a perpetrator to leave the family home for up to 48hrs. DAPO can then be applied for by the police via the Magistrates Court. Victims or third parties will also now be eligible to apply for a DAPO directly to a family court. Criminal, Family and Civil courts will also be able to grant a DAPO of their own volition during existing court proceedings which do not have to be domestic abuse related. DAPOs will allow prohibitions and positive requirements to be imposed on perpetrators. These could include prohibiting the perpetrator from coming within a specified distance of the victim’s home and/or any other specified premises, such as the victim’s workplace, alongside requiring the perpetrator to attend a behaviour change programme, an alcohol or substance misuse programme or a mental health assessment.Requirements imposed by a DAPO can be changed by the courts so that they can respond to changes over time in the perpetrator’s behaviour and the level of risk they pose.Courts will also have the power to use electronic monitoring (‘tagging’) to monitor a perpetrator’s compliance with certain requirements imposed by a DAPO.

**6.5 Domestic Homicide Reviews (DHR)**

When someone has been killed because of domestic abuse(domestic homicide) or committed suicide because of domestic abuse a domestic homicide review should be carried out. Professionals need to understand what happened in each homicide and to identify what needs to change to reduce the risk of future tragedies. The practice must cooperate with such reviews, share information and participate in practitioner events if asked to do so.This is a statutory requirement and includes victims from age 16 years. Learning from DHR’s both locally and nationally has demonstrated the GP practicesare well placed to identify domestic abuse and to facilitate signposting for specialist support.

**6.6Perpetrators of Domestic Abuse**

Part of the Violence Against Women and Girls Strategy is to improve work with perpetrators. If a service user male or female requests help in addressing their abusive behaviour GP practices can signpost them to local Domestic Abuse services for referral to a Perpetrator Programme.

**7.0 Recording of Domestic Abuse on EMIS Electronic Medical Record**

It is just as important to record and code information about domestic abuse on medical records as it is any other clinical data. However, care should always be taken to protect information related to domestic abuse on adult and children records from being seen by the perpetrator. All information about domestic abuse must be hidden from patient online access this includes the victim, children and perpetrator records. Be aware that a perpetrator may attempt coercive access to the victim or child records. Always redact information related to domestic abuse when printing off summaries or handheld records or patient copies of referrals. Also ensure that any reference to domestic abuse is not visible to the perpetrator during appointments. Recording and application of Snomed codes should beas per RCGP guidance regarding information related to domestic abuse or MARAC (MARRAC in BWD).

<https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/-/media/4C306F19A1204842AC41EF303049F9A7.ashx>

 **8.0 TRAINING**

Duke Street Surgerysupports staff to be trained in awareness of domestic abuse and where appropriate to their role trained in responding to Domestic Abuse disclosures.

Recommendations following the implementation of the Domestic Abuse Act 2022 state that all NHS staff should receive domestic abuse training.  This includes patient facing and non-patient facing staff.  Levels of domestic abuse training should be appropriate to each staff members role. Clinical staff should have domestic abuse training at L3

Further information on NICE guidance and recommendations can be found at: <https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-2-Response-to-domestic-violence-and-abuse>

RCGP<https://www.rcgp.org.uk/clinical-and-research/safeguarding/domestic-abuse.aspx>

Training can also be accessed through:

 Lancashire:Adult and Children: [Learning & Development](http://www.lancashiresafeguarding.org.uk/learning-development.aspx)

 South Cumbria: Adult - [Training and Learning](https://www.cumbriasab.org.uk/)

 South Cumbria: Children - [Training and Learning](https://cumbriasafeguardingchildren.co.uk/)

 North Yorkshire: Adult - [Training Courses](https://www.nypartnerships.org.uk/sab)

North Yorkshire: Children - [Training Courses](https://www.safeguardingchildren.co.uk/training-north-yorkshire/training-courses/)

**Appendix 1**

**Local flowchart for Responding to Domestic Abuse**

**Domestic Abuse Suspected**

If indicators present e.g:

Physical Injury Depression

Frequent Attendance Self Harm

Non-Specific SymptomsFatigue

Delay in Presentation Genital Injury/STI’s

Make safe enquiry

(Sensitive, Alone, safe environment)

DA Disclosed

DA Denied but still suspected

Discuss Risk

Is there immediate danger?

No – advise or give contact details of Domestic Abuse Services. Document on records and arrange follow up

Are there children to be considered?

Yes – contact police (if no consent given but high risk indicated report to police without consent) contact Domestic Abuse Services for specialist support &document on records

Yes – immediate danger – as above and make safeguarding referral to Children Social Care

Yes – but not immediate danger. Discuss effects on children sensitively. Make a Safeguarding referral to Children Social Care if children are being or at risk of being subjected to effects of domestic abuse including emotional harm. Share information with relevant professionals e.g. HV S/N. document on records

Explain and document all disclosures and injuries for the purpose of evidence.

Use body map for injuries.

Share information appropriately and document if consent has been obtained or not.

Use appropriate Snomed codes to indicate disclosures of parental Domestic Abuse and link with Children’s records where appropriate.

Signpost to local Domestic Abuse Services

No – Action as above



**Appendix 2**

**FGM Pathway**

**Appendix3**. **Useful Contact Details:**

* **Lancashire Social Care:**
* Children Tel: 0300123 6720
* Adults Tel: 0300 123 6721
* Out of hours Duty Team Tel: 03001236722
* **Blackburn with Darwen Social Care**
* Children Tel: 01254 666400
* Adults Tel: 01254 585949
* Out of hoursDuty Team Tel: 01254 587547
* **Cumbria Social Care**
* Children Tel: 0333 240 1727
* Adults Tel: 0300 303 2704
* Out of hours Duty Team Tel: 0300 303 2704
* **North Yorkshire Social Care**
* Children Tel: 01609 780 780
* Adults Tel: 01609 780 780
* Out of hours Duty Team Tel: 01609 780 780

**Domestic Abuse Services:**

* **Lancashire**

Domestic Abuse Services Tel: 0300 323 0085

* **Blackpool**

Fylde Coast Women’s Aid Tel: 01253 596699

* **Blackburn with Darwen**

WISH Centre Tel: 01254 260465

* **Cumbria**

Domestic Abuse Partnership Tel: 01228 817200

* **North Yorkshire**

County Council Tel: 01609 780 780

* **National Women’s**

Refuge Tel: 0808 2000 247

* **National Men’s**

ManKind Initiative Tel: 01823 334 244

* **Galop**(previously Broken Rainbow)

LGBT + Domestic Abuse Helpline Tel: 0800 999 5428

[www.galop.org.uk](http://www.galop.org.uk)

Sexual Assault Referral Centre Lancashire SAFE Centre / The Lancashire SAFE (Sexual Assault Forensic Examination) Centre provides forensic examinations, advice and comprehensive support services for women, men and children of all ages who make a complaint of rape or sexual assault. Tel: 01772 523 344

**Appendix 4: EMIS Templates for Routine Enquiry Pennine Lancs**

Local and national Domestic Abuse Homicide Reviews have recommended that GP Practices should ask about domestic abuse in Mental Health related consultations. In response to this recommendation the CCG and EMIS have developed a template for GP’s to complete demonstrating the use of routine enquiry. A prompt to use the Routine Enquiry Template for Domestic Abuse will be triggered during mental health related consultations, including:

* Low mood
* Depressed mood
* Panic attack
* Panic disorder
* Anxiety disorder
* Anxiety state

The prompt below will pop up:



If the GP ticks yes they will be taken to the template below:



Safe Routine Enquiry has also been added to the EMIS Templates for Women’s maternal and sexual health checks, NHS Health checks and general health checks and the neurology template.

Whenever domestic abuse is discussed with a patient it is important to understand that discussing these issues can be very traumatic for victims. A trauma informed approach should be used.

**Appendix 5 : REFERENCES:**

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**Appendix 6 - Version Control**

**Sample GP Domestic Abuse Policy**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Primary Care Sample Policy** | **Date** | **Author**  | **Status** | **Comment / Details of Amendments** |
| 3.0 | February 2022  | Lancashire & South Cumbria ICS Safeguarding Policy Group | Draft | Policy review and amended to reflect changes of the Domestic Abuse Act 2021 and to reflect local and national policy developments regarding domestic abuse.Throughout the document the term “domestic violence and abuse” has been changed to “domestic abuse”. The term “vulnerable adult” has been replaced with “adult at risk”.Section 2.0 The definition has been amended in light of the DA Act 21(this may need further alteration when national stat definition is published). Explanation of types of abuse has been added to including Children being victims in their own right, Economic Abuse, invalid consent, non-fatal strangulation and threats to share indecent images.Section 2.1 has been altered under heading familial abuse to include adult child to parent abuse as well as adolescent child to parent abuse. The term child/young perpetrator has been removed and replaced with “ young person using harmful behaviours”. Section 2.4 Heading changed to “So called” HBA. Section 2.5 has been amended to include response to adults at risk re FGM. Section 3 DA Act added to Roles and Responsibilities re training, identifying and responding to DA. In section 4.0 requirement that NHS can no longer charge for DA Evidence reports added. Section 5.2 Routine Enquiry guidance added and use of EMIS template. The use of the template is dependent on ICB locality decision. Section 5.3 added - Safe Guidance during T/C consultations. Section 5.4 risk factors added to. Section 5.6 Children being seen as victims in their own right added to Impact on CYP. % Of male perpetrators taken out as difficult to clarify true sourceSection 6.0 Routine Enquiry taken out and moved above under Identifying domestic abuse as this section is related to response. Response expanded to include referral and signposting.Section 6.2 BWD MARRAC added as mentionedSection 6.4 DVPN & DVPO updated in line with DA Act 21 re DAPN & DAPO. Section 7.0 on Recording of DA updated – will need further amendment when local guidance agreed The term LGBT has been replaced with LGBT+  |

**Circulation List**

Following Approval this Policy Document will be circulated to:

**Primary Care Practices across Lancashire and South Cumbria ICS**

**Review of Policy: This document will be reviewed in 2024 or before this date in the event of national updates.**

This sample Safeguarding Policy is based on the Lancashire & South Cumbria Safeguarding Adults Board procedures and Lancashire and South Cumbria Children's Safeguarding Assurance Partnership (CSAP) and the Domestic Abuse Act 2021. It will support Primary Care to promote identification and response towards victims/survivors, children and perpetrators of Domestic Abuse.

This is a sample policy which Primary Carepersonalise for use within their own Practice or use to support development of their own policies and procedures.

It has been developed by the safeguarding adult and children’s team across Lancashire and South CumbriaCCG’s.