Morecambe Bay

Primary Care Collaborative

Domestic Abuse Policy

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1. INTRODUCTION

1.1 Summary

MBPCC is committed to support staff within Primary Care to identify and respond to domestic abuse appropriately and safely.

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

Domestic violence and abuse rarely exist in isolation. The impact of living with adult violence 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. Domestic Violence and abuse are considered a violation of Human Rights.

1.2 Purpose

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

MBPCC is committed to implementing this policy and the practices it sets out. MBPCC will provide learning opportunities and make provision for appropriate domestic abuse training to all employees. This policy will be made widely accessible to employees and reviewed every 24 months.

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 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 MBPCC CEO and MBPCC lead for safeguarding, to brief the staff and partners on their responsibilities under this policy.

MBPCC 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 adults are 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 violence and abuse.
- Clear lines of accountability within MBPCC for domestic violence and abuse.
- 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 violence and 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.

Pan Lancashire: Policy and Procedures for Safeguarding Children Manual

Cumbria: Safeguarding Children Board Procedures Manual

1.3 Scope

This policy applies to all MBPCC employees and directors.

From time-to-time MBPCC may utilise the resources of sub-contractors to deliver contractual obligations. For avoidance of doubt, where a sub-contractor is providing care to patients, as laid out in the contracts between MBPCC and subcontractors, they are solely responsible for delivery of the regulated activity they are providing and must ensure all their employees operate under their own policies which must meet the relevant CQC standards. MBPCC will seek assurance from all sub-contractors that suitable policies are in place and may at their discretion request copies of any relevant policies for review and for verification. In such cases this policy document does not apply.

2. PROCEDURE

2.1 Definition and Types of Domestic Violence and Abuse (DVA)

The Home Office definition of Domestic Abuse (2012) is:

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

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. Domestic abuse can also occur in lesbian, gay, and transgender relationships. Heterosexual females also abuse heterosexual men and children may abuse adults. and transgender relationships. Heterosexual females also abuse heterosexual men and children may abuse adults.

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, 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 risk in all types.

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, 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, prevention of breastfeeding or being forcibly subjected to pornographic or violent sexual material and forced marriage.

Psychological and 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.

This 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.

Financial - Controlling financial resources in a way that blocks the victim's access to them when needed. It may include denying access to money or credit cards; refusing to pay bills; denying food, clothing, and transportation or gambling.

Controlling or coercive behaviour

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

It has been widely understood for some time that coercive control is a core part of domestic violence. As such the extension does not represent a fundamental change in the definition. However, it does highlight the importance of recognising coercive control as a complex pattern of overlapping and repeated abuse perpetrated within a context of power and control.

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

As stated in the Home Office definition of domestic abuse (2012):-

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

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

Types of controlling and coercive behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence in their own right. It is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged. However, the perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim. Such behaviours might include:

- 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 dehumanise 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 HM 2015)

Adolescent to parent violence and abuse

Adolescent to parent violence and abuse (APVA) may be referred to as 'adolescent to parent violence (APV)' 'adolescent violence in the home (AVITH)', 'parent abuse', 'child to parent abuse', 'child to parent violence (CPV)', or 'battered parent syndrome.

There is no legal definition of adolescent to parent violence and abuse, but it is an increasingly recognised form of domestic abuse. From the age of 16years this type of domestic abuse falls under the Home Office Domestic Abuse definition however it should be recognised that APVA can also involve young people below 16 years of age.

APVA can 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 perpetrator. There are many factors which can contribute and or exacerbate APVA 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 young perpetrator, addressing their own and the health needs of the young perpetrator and protection of other family members such as siblings.

APVA can be serious, and risk can exacerbate, 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:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732573/APVA.pdf

Honour Based Abuse

The Crown Prosecution Service definition of Honour Based Abuse (2018) is "A crime 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. 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. (REF Crown Prosecution Service, Legal Guidance, Domestic Abuse "Honour – Based "Violence 2018)

The Police and Domestic Abuse Services can support victims of honour-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.

Professionals can request advice from the specialist local police team via telephone: 01254 353638 but referrals should be made via 101 or 999.

Forced Marriage

There is a clear distinction between a forced marriage and an arranged marriage; everyone should have the right to choose. 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, financial, 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.

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 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 MBPCC need to be aware of their responsibilities and obligations when they are faced with forced marriage cases. If the victim is allowed to leave MBPCC 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. Pan Lancashire adult and children safeguarding procedures must also be followed. Family/friends must never be used as interpreters and records must be kept strictly confidential

Forced 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 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 local referral procedures must also be followed.

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)

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 vulnerable adults which they identify in the course of their professional work to the police. The duty came into force on 31 October 2015

Childrens Social Care Safeguarding referrals should also be made regarding any under 18 year old female known to have had FGM. Specialist forensic examination and support may be required which would be agreed during a Strategy discussion.

'Known' cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the professional observes physical signs on a girl 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 a vulnerable adult) to the police but safeguarding responses need to be considered. Possible wider issues found within FGM practising communities will need to be explored with a woman, i.e., domestic abuse; honour-based violence 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 Childrens 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 that 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 has been amended to incorporate Lancashire procedures and can be found in Appendix 1 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 a vulnerable adult has 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 Health and Social Care Information Centre.

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 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

- North Lancashire: Pan Lancashire Multi-Agency Pathway for Children
- South Cumbria: Female Genital Mutilation

2.2 Roles and Responsibilities in Primary Care

The NHS is often the first point of contact for victims who have experienced Domestic Violence or Abuse. The health service especially Primary Care plays an essential role in responding to helping prevent further Domestic Violence or Abuse by intervening early, providing treatment and information and referring patients to specialist services. As highlighted Domestic Violence and Abuse is 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 survivors of Domestic Violence 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.

2.3 Information Sharing

Sharing of information is vital for early intervention to ensure that adults 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 information sharing refer to Information sharing: Guidance for practitioners and managers (HM Government 2018)

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

2.4 Identifying and Recognising Domestic Violence and Abuse

A GP or practice nurse may be the first 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 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 had children or is pregnant.

Identifying Domestic Violence and Abuse

Staff should endeavour to recognise service users whose symptoms mean they might be more likely to be experiencing domestic abuse. Often people suffering domestic violence or abuse have unnecessary investigations and medication for nonspecific or mental health symptoms. 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. https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse

Risk factors for Domestic Violence and Abuse

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

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).

Impact on Children and young people

Research tells us there is a significant link between violence 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 or not. Living with Domestic Violence and 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.

Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress which may express itself in different ways. The child may become withdrawn or extraverted and this 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 violence and abuse is exacerbated when the abuse is combined with substance misuse as this can increase the severity of the attacks.

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

Signs displayed by children that may be living with DVA

- 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

Unborn Child

The unborn child can also be affected by physical violence; 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)

Impact of Domestic Violence and Abuse on parenting

Living with Domestic Violence and Abuse does not automatically result in poor parenting; this depends on a range of factors including adverse childhood events (ACE's) for the parent, consideration of domestic violence and 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.

Domestic Violence and 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 and all complex cases can be discussed with LSCFT Safeguarding Team in the first instance.

Male Victims

Although the majority of known victims are female it is important to understand that males can also be victims of domestic violence and abuse. 20% of known victims are male. 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 from Lancashire will be offered support from domestic abuse services and there is also some safe housing provision and available accommodation for males with children

Lesbian Gay Bisexual and Transgender Groups (LGBTQ+)

It is known that 1:4 lesbian and bisexual 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 LGBTQ+ 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.

Domestic abuse in teenage interpersonal relationships

Research shows that many young people experience Domestic Violence and Abuse in their own intimate relationships (NSPCC & Bristol University 2009) and young people exposed to domestic violence in childhood are more likely to experience violence and 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 violence 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 Childrens Social Care for assessment of risk

2.5 Responding To Domestic Violence and Abuse

Routine Enquiry of Domestic Abuse

Primary care professionals may be alerted to the possibility of Domestic Violence and Abuse involving children in a number of different ways. Routine enquiry into domestic abuse can 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.

If a service user presents with health markers associated with domestic abuse as highlighted in section 5.1 enquiry into domestic abuse should be made. 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 your finances? Does anyone make you feel scared?”

Be familiar with and give relevant information about local domestic abuse agencies that can provide safety planning and support for the victim.

Focus on safety and assess the immediate safety of the victim and any children. Consult with your safeguarding lead/ manager and consider the completion of a Safe Lives DASH Risk Indicator Checklist if trained to use this.

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

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 at high risk of serious injury or murder a referral to MARAC (Multi Agency Risk Assessment Conference) should be made. At this point immediate safety measures 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 a vulnerable adult referral 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.

Known or suspected domestic violence and abuse should be recorded in the victims health records (not handheld records) and identified as a specific concern on all referral and assessment forms. Those involved should be asked if they are safe at the moment and given appropriate advice and support if not.

NB. Any concerns regarding immediate risk to victims and children or threats to kill should be reported to the police. Tel 999

Role of 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.

Multi Agency Risk Assessment Conference (MARAC)

A MARAC is a multi-agency meeting, which has the safety of high-risk victims of domestic abuse 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.

Domestic Violence Disclosure Scheme (DVDS) 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 violence 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.

Employees 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. MBPCC staff would not inform the victim or perpetrator that the application was being made.

Domestic violence protection notices and orders

Domestic violence protection orders (DVPOs) have been implemented across England and Wales since 8 March 2014. This follows the successful conclusion of a 1-year pilot in the West Mercia. Domestic violence protection orders are a power that fills a gap in providing protection to victims by enabling the police and magistrates to put in place protection in the immediate aftermath of a domestic violence incident.

With DVPOs, a perpetrator can be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

Domestic Homicide Reviews (DHR)

When someone has been killed as a result of domestic violence (domestic homicide) a 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. MBPCC 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 primary care are well placed to identify domestic abuse and to facilitate signposting for specialist support.

Perpetrators 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 behaviour, employees can signpost or refer them to appropriate services.

WISH Centre in Blackburn telephone: 01254 260465 are the commissioned service in Lancashire for delivering the voluntary perpetrator programme. Employees can refer or signpost perpetrators to this service.

2.6 Training

MBPCC supports staff to be trained at level 1 and 2 where appropriate to their role in responding to Domestic Violence and Abuse disclosures.

Level 1 – Staff will be trained to respond to a disclosure of Domestic Violence and Abuse sensitively and in a way that ensures people's safety. Nice guidance recommends that this level of training is suitable for physiotherapists, speech therapists, dentists, youth workers, care assistants, receptionists, interpreters and non-specialist voluntary and community sectors. Staff trained at level 1 should be able to direct people to specialist services, it is however expected that staff members falling into this category seek advice and support from the safeguarding lead in responding to the disclosure.

Level 2 – Staff should be trained to ask about Domestic Violence and Abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of Domestic Violence and Abuse, how it affects people's lives and the role of professionals in intervening safely. Staff should be able to respond with empathy and understanding, assess someone's immediate

safety and offer referral to specialist services. Typically, this level of training is for nurses, GPs, ED doctors, ambulance staff, mental health professionals, midwives, health visitors, paediatricians and other staff working closely with families and adults with care and support needs.

Staff that fall under this category are expected to respond to all disclosures of Domestic Violence and Abuse empathetically and safely and refer to the appropriate agencies for support. Support and advice should be sought from the safeguarding lead if needed. 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: http://www.e-lfh.org.uk/programmes/domestic-violence-and-abuse/open-access-sessions/

- North Lancashire: Learning & Development
- South Cumbria: Training and Learning Events

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Domestic Violence - Royal College of General Practitioners http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx

Domestic violence and abuse - Detailed guidance - GOV.UK https://www.gov.uk/guidance/domestic-violence-and-abuse

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4. DEFINITIONS/GLOSSARY OF TERMS

Abbreviation or Term	Definition
CEO	Chief Executive Officer
MBPCC	Morecambe Bay Primary Care Collaborative
CQC	Care Quality Commission
DVA	Domestic Violence and Abuse
FGM	Female Genital Mutilation
APVA	Adolescent to parent violence and abuse
APV	Adolescent to parent violence
AVITH	Adolescent violence in the home
CPV	Child to parent violence
FMU	Forced Marriage Unit
WHO	World Health Organisation
FC	Female circumcision
FGC	Female genital cutting
CAP	Clinical Audit Platform
PTSD	Post-traumatic stress disorder
LCFT	Lancashire Care NHS Foundation Trust
LGBT	Lesbian Gay Bi-sexual and Transgender
LAC	Looked after children
MARAC	Multi Agency Risk Assessment Conference
IDVAs	Independent Domestic Violence Advisers
DVDS	Domestic Violence Disclosure Scheme
DVPO's	Domestic Violence Protection Orders
DHR	Domestic Homicide Reviews
NICE	National Institute for Health and Care Excellence

DH	Department of Health
SAFE	Sexual Assault Forensic Examination

5. CONSULTATION WITH STAFF, PRACTICES AND PATIENTS

Name	Job Title	Date Consulted
Emma O'Kane	Safeguarding and Quality Practitioner	27/08/2020

6. DISSEMINATION/TRAINING PLAN

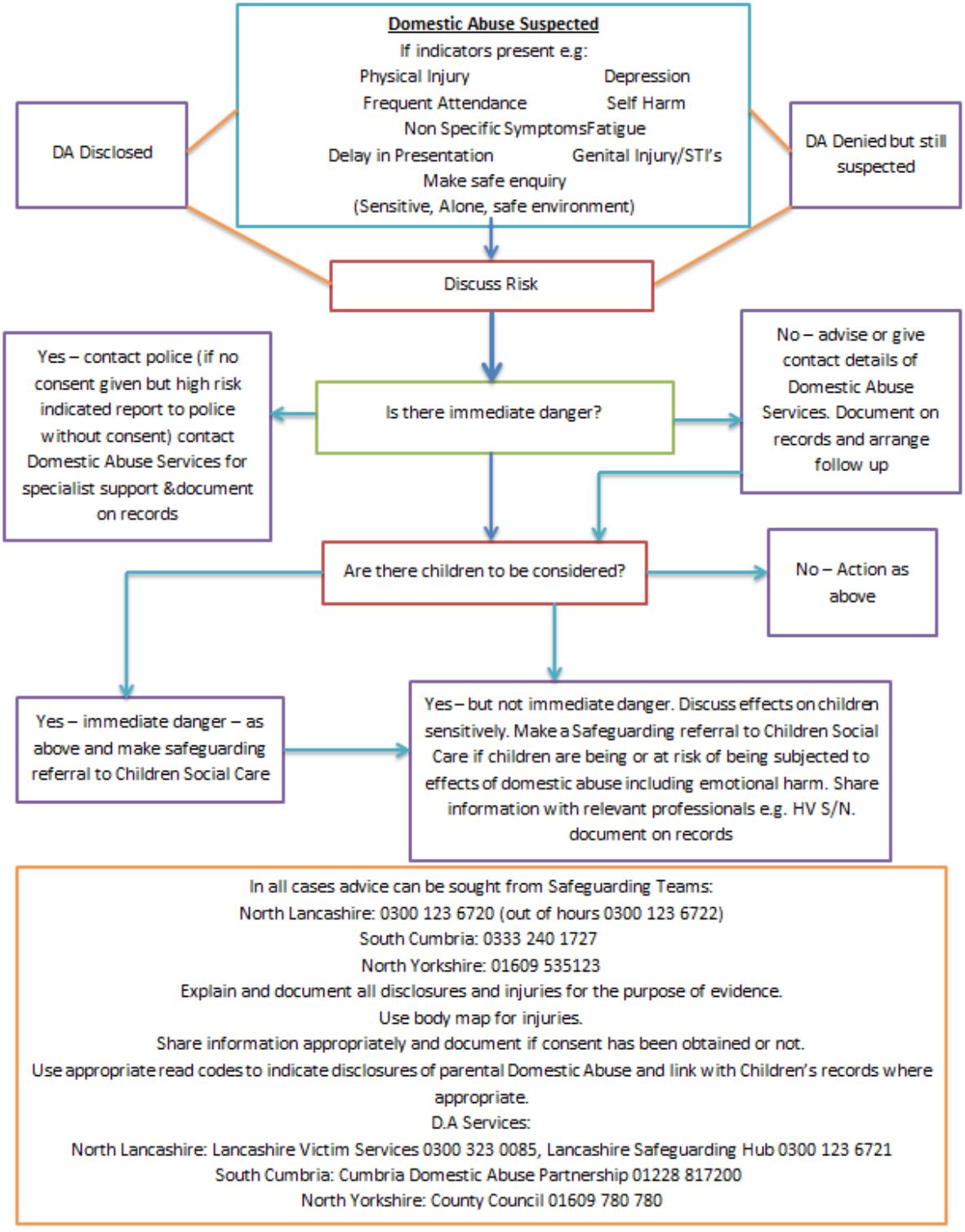
Action by	Action Required	Implementation Date
Jo Knight/Boyana Konar	Upload policy to MBPCC website	Following approval of V0.1 end Sept 2020
Jo Knight	Host current copy on Federation G Drive (supporting induction process), updating Policy tracker	Following approval of V0.1 end Sept 2020
Andrew Giles	Ensure all employees are aware of the policy and are asked to read and understand it	MBPCC Board Meeting 22/09/20
Liz Stedman	Upload to TeamNet	Jan 2021

7. AMENDMENT HISTORY

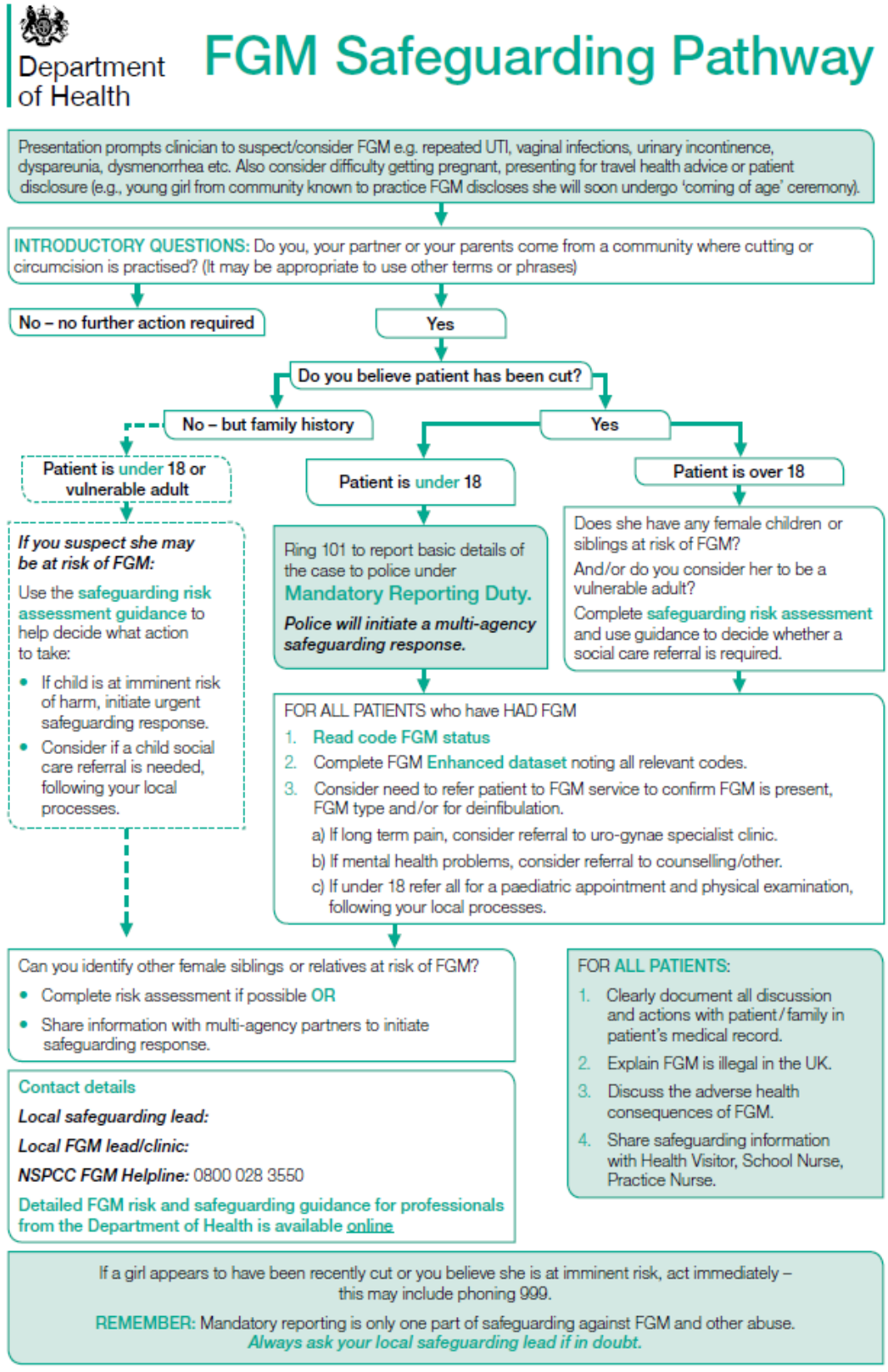
Version No.	Date of Issue	Section/Page changed	Description of change	Review Date
V0.1	20/09/2020	All	New policy -adoption of the CCG model policy	N/A
V1.0	22/09/2020	N/A	MBPCC Board Approval	22/09/2022
V1.1	20/01/2021	Page 1 Page 20	MBPCC email address updated Additional Definitions/Glossary of Terms added	
V1.2	26/01/2023		Amends to grammar and updates to organisational details	01/2025
V2.0	01/04/2023		MBPCC Board Approval	01/04/2026

8. APPENDICES

Appendix 1: Flow chart for responding to domestic violence and review



Appendix 2: DoH FGM Safeguarding Pathway



Appendix 3: Useful Contact Details

- Lancashire Social Care
  - Adults/Children — Tel: 0300 123 6720
  - Out of hours Duty Team — Tel: 0300 123 6722
- Cumbria Social Care
  - Children — Tel: 0333 240 1727
  - Adults — Tel: 0300 303 2704

Domestic Abuse Services:

- Lancashire Domestic Abuse Services — Tel: 0300 323 0085
- Cumbria Domestic Abuse Partnership — Tel: 01228 817200
- National Women's Refuge — Tel: 0808 2000 247
- National Men's ManKind Initiative — Tel: 01823 334 244

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

Galop (previously Broken Rainbow) / National advice for LGBT victims www.galop.org.uk Tel: 0800 999 5428.