

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURES FOR RESPONDING TO DOMESTIC ABUSE and DOMESTIC
INCIDENT REPORTS

1.0 INTRODUCTION

1.1 This procedure offers guidance on Domestic Abuse which includes

- Coercive control
- Female Genital Mutilation
- Forced Marriage and Honour Based Abuse
- Hate Crime

1.2 The Home Office 2013 updated the definition of domestic violence and abuse to reflect that many young people are experiencing domestic abuse and violence in relationships at a young age and may therefore be Children in Need or likely to suffer significant harm. Domestic abuse is defined as:

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

The abuse can encompass;

- Psychological
- Physical
- Sexual
- Financial
- Emotional

1.3 In December 2015 the offence of Coercive Control came into force in England and Wales.

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

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.

1.4 Prolonged and/ or regular exposure to domestic abuse can have a serious impact on children’s safety and welfare, despite the best efforts of parents to protect them. An exploration of the possible impact on the unborn child shows the foetus is at risk of injury because violence towards women increases both in severity and frequency during pregnancy, and often involves punches or kicks directed at the women’s abdomen.

- 1.5 All children living in a household where there is domestic abuse will be affected. Those children that witness domestic abuse can be significantly affected both emotionally and behaviourally and suffer physical abuse.
- 1.6 Both men and women can be victims of domestic abuse though a greater proportion of women experience all forms of domestic abuse and are more likely to be seriously injured or killed by their partner or ex- partner.
- 1.7 Domestic incident reports are produced by the police and distributed to Community Healthcare services and some mental healthcare services within the Trust when an incident occurs involving a family where children are likely to or known to be present.
- 1.8 In April 2011 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). A DHR review means a review of the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
 - A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
 - A member of the same household as him/herself,

The purpose of a DHR will be to identifying the lessons to be learnt from the death and relevant Trust Staff involved will be required to discuss the case with the identified member of staff conducting an Individual Management Review. Further guidance on the procedure for DHR is available in the Trust Safeguarding Adult Procedure CLPG39 Appendix 3.

2.0 PURPOSE

- 2.1 This procedural guidance supports the three central imperatives of intervention for children living within domestic abuse and violence which are:
 - To protect the child or children including an unborn.
 - To empower the victim/ to protect her/himself and the children.
 - To identify the abusive partner.

3.0 PROCESS

- 3.1 The Trust has different processes in place for responding to Domestic Incidents in accordance to the local police departments arrangements. Therefore staff should follow the general process below but be aware of specific process for their areas of work. Staff should contact their Safeguarding Named professional for advice if they are unclear or access the Safeguarding Intranet site

- 3.2 Staff should be able to recognise indicators and know how to respond to domestic abuse to safeguard children and the victim. When domestic abuse is identified staff should:
- Focus on the victim's safety and that of their children.
 - Share relevant information and refer if required to relevant agencies e.g.GP, Social Care.
 - Support and reassure the victim.
- 3.3 When talking to an individual about domestic abuse staff should **never**:
- Discuss the situation or potential risk when another person is present.
 - Promise confidentiality if there are children in the family.
 - Accept culture as an excuse for domestic abuse.
 - Force the victim to make a disclosure.
 - Encourage them to immediately leave the family home.
- 3.4 If a referral to social care is required staff should inform the parent, unless it is felt that this may cause additional risk of harm to the victim or a child.
- 3.5 Where there is evidence of domestic abuse, the implications for any children in the household must be considered and a referral to Children's Social Care **must** be made where staff are aware of;
- A child's direct involvement with a domestic abuse incident or injury;
 - A victim who is a woman and is pregnant. Pregnant women frequently experience punches and kicks directed at the abdomen, risking injury to both mother and foetus;
 - Any child injured during episodes of violence or is witnessing the physical and emotional suffering of a parent.
- 3.6 Where an interpreter is required, **never use a family member** as in cases of honour based violence there is a high likelihood that this will increase the risk of serious harm to the victim and children
- 3.7 Where there are no Safeguarding children concerns and the person requests that no further action should be taken regarding domestic abuse then staff must
- Decide if the person has capacity to make an unwise decision.
 - Consider risks to others including other family members.
 - Advise on support services available.
- 3.8 Victims of Domestic Abuse may remain with an abusive partner for many years whilst suffering abuse without considering leaving or sometimes not recognising that they are living within an abusive relationship.

Staff must consider the welfare of any child or another adult where there are additional areas associated with domestic abuse. Including the below.

3.9 Female Genital Mutilation

3.9.1 Female Genital Mutilation (FGM) is known by a variety of names including 'Female Genital Cutting', 'Circumcision' or 'Initiation'. However FGM is the most recognised name used by professionals and community settings.

3.9.2 FGM is prevalent in 30 countries concentrated around Africa, Middle East and some countries in Asia. It has also been identified in Europe, North America and Australia.

The practice is NOT required by any religion

3.9.3 FGM is a form of violence against women and girls which is in itself both a cause and consequence of gender inequality. As such it can be associated with other discriminatory forms of honour based violence including forced marriage and domestic abuse.

3.9.4 FGM is defined as the removal of part or all of the female genitalia for non – therapeutic reasons. It is frequently a very traumatic and violent act for the victim and can cause severe pain, mental health problems, genito urinary problems and difficulties in childbirth.

3.9.5 FGM is illegal in the UK. It is a criminal offence not only in the UK but includes taking a child abroad to undergo FGM, whether or not it is lawful in that country.

3.9.6 The FGM Act 2003 states that health professionals have a **mandatory duty** report known or potential cases of FGM in under 18's to social care and the Trust Safeguarding team.

3.9.7 A child for whom FGM is planned is likely to suffer significant harm through physical abuse and emotional abuse, which is categorised by some also as sexual abuse.

3.9.8 Health professionals encountering FGM should be alert to the risk of FGM for siblings, daughters and /or extended family members.

3.10 Honour Based Violence

3.10.1 Honour Based Violence is committed against someone who is perceived to have brought shame or dishonour on a family or even a community. Incidents that have preceded honour killing have included:

- Attempts to separate or divorce.
- Threats to kill or denial of access to children.
- Pressure to go abroad and forced marriage.

3.10.2 A child who is at risk of Honour Based Abuse is at significant risk of physical harm including being murdered. Staff suspecting Honour Based Abuse should refer to social care and the Trust Safeguarding Team. They should NOT discuss with family members.

3.10.3 Accurate record keeping is essential when managing a case involving honour based abuse. Practitioners should ensure that they use the child's words verbatim, date and time the details and make note of any injuries using body maps where indicated.

3.10.4 It is important to see the child on their own even if they are accompanied by others and establish a mechanism of contacting them discreetly in the future.

3.11 Forced Marriages

3.11.1 In June 2014 it became a criminal offence to force someone to marry. A child who is being forced into marriage is at risk of significant harm from physical, sexual and emotional abuse.

3.11.2 Warning signs include:

- Family history of an older sibling leaving the country suddenly or marrying early.
- Anxiety, depression or emotionally withdrawn.
- Absence from school or other regular activity.
- Fear of forthcoming visits to their country of origin.
- A child going missing/running away.
- A child talking about an upcoming family holiday they are worried about.
- Surveillance by family members especially siblings.
- A child directly disclosing that they are worried s/he will be forced to marry.

3.11.3 Staff suspecting Forced Marriage should contact Social Care and the Trust Safeguarding Team immediately. They should not approach or discuss with the family. Staff should follow the same guidance as indicated for Honour Based abuse in relation to record keeping and seeing the child alone.

3.12 Hate Crime/Incidents

Hostility or prejudice towards an identifiable group of people (race, religion, disability or sexual orientation). Incidents often involve physical assault, bullying, hate mail. Where there may be risks to other adults from the perpetrator then staff should consider a Safeguarding Adult Referral (Trust Safeguarding Adult Procedure CLPG39).

3.13 Spiritual Possession and Witchcraft

Children are at risk of harm where parents, families and the child themselves believe that an evil force has entered a child and is controlling them, the belief includes the child being able to use the evil force to harm others. Parents can be initiated into and/or supported in the belief that their child is possessed by an evil spirit. A child may suffer emotional abuse if they are labelled and treated as being possessed with an evil spirit. In addition, significant harm to a child may occur when an attempt is made to 'exorcise' or 'deliver' the evil spirit from the child.

4.0 DOMESTIC INCIDENT REPORTS DIR

- 4.1 There are separate domestic abuse protocols within Children's Community Health Services that relate to the process for Domestic Incident Reports (DIR). DIR are sent electronically by the police to Trust Safeguarding Children Teams via secure NHS mail account. Some are also sent to Children's Social Care.
- 4.2 A copy of the DIR will be distributed to the named professional e.g. health visitor, school nurse. Staff must ensure the information is assessed against the child or parent records and an action plan developed if required. A copy should be filed within the child or adults record where appropriate and in accordance to local protocol.
- 4.3 All DIR received involving pregnant women are distributed to the relevant midwife or hospital as per the protocol for Information sharing in respect of domestic abuse involving a woman in the antenatal period.
- 4.4 Staff receiving DIR will discuss with other relevant staff in order to safeguard the unborn or other relevant children or adults. A discussion with GP and relevant mental health professional should take place to share information and establish if there are any additional concerns.
- 4.5 Community Health Practitioners will prioritise the actions they take based on
- The number of incidents.
 - There is a current or previous child protection plan.
 - The incident has been identified as high or very high risk by the police.
 - The child is subject to a child in need plan.
 - Pregnancy.
 - Knowledge of the family and any previous concerns.
- 4.6 Some DIR's are notified to social care by the police however staff should not assume that Social Care will have all information regarding the child or family. If a DIR is received for the criteria above then staff should contact Social Care to establish any action to be taken by all involved professionals.

- 4.7 Caseload holders must record all incidents using the appropriate forms (e.g. Chronology of Events /selective intervention template) used by teams. This must include the nature of the incident, the assessment of its impact on the child or young person and the resulting action plan.
- 4.8 Where a DIR is received and a school child attends a school out of area then the Safeguarding Team will forward the DIR to their counterpart team in the relevant area.
- 4.9 When a DIR is received and the parent/child is not registered with a GP then the relevant professional should be notified in the geographical area that the child/parent is resident.
- 4.10 The Safeguarding Children team will provide supervision on cases where the practitioner has concerns for the impact of the domestic abuse on the child or young person.

<p>5.0 DOMESTIC ABUSE STALKING & HARASSMENT (DASH) RISK ASSESSMENT & MULTI AGENCY RISK ASSESSMENT CONFERENCE (MARAC)</p>

- 5.1 Where staff have concerns regarding a victims safety following the receipt of a domestic incident a DASH risk assessment tool can be used to help aid a discussion between staff and victim and assess the level of risk to victim and any others including children. The DASH tool is available via the Trust Safeguarding Intranet site.
- 5.2 Where a DASH has been completed and reaches the threshold (14 ticks) or where professional judgement dictates, then a referral to the Multi Agency Risk Assessment Conference (MARAC) by the practitioner or the Trust local representative or Domestic Abuse Lead.
- 5.3 MARAC meetings are attended by local representatives from organisations which may be involved in supporting victims, or working with the perpetrator. MARAC's occur regularly (monthly or more frequently) across the Trust area and are chaired by police.
- 5.4 The purpose of a MARAC is to share information about Very High Risk victims in order to prevent serious harm, develop a safety plan, put all possible support in place and lower the risk to children and victim as soon as possible.
- 5.5 The Trust is represented at MARAC by identified senior practitioner e.g. Care Co-ordinators, Criminal Justice Teams and Specialist Community Health service staff.

- 5.6 All staff attending MARAC should provide information to aid assessments and reduce risk. Staff should check with Children's Social Care that any child or unborn is known and if not a referral should be made.
- 5.7 Most MARAC will have an Independent Domestic Violence Advocate (IDVA) who is able to act as a bridge between the victim and the MARAC meeting and act as the primary point of contact for the victim. And offer support during any court proceedings.

6.0 RECORD KEEPING

- 6.1 It is important that staff follow the Trust, and local team record keeping policy and procedure. All actions and reasons for not taking action should be recorded clearly.
- 6.2 Staff should note that any Trust records containing information on domestic abuse may be used for:
- Criminal proceedings.
 - Civil proceedings regarding contact arrangements between perpetrators and children.
 - Domestic Homicide Reviews.
 - Housing provision.

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