NHS
Warwickshire North
Clinical Commissioning Group

Domestic Abuse Policy

Quality & Equality First

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Contents

1.0 Introduction

This policy reflects local, national, strategic and operational guidance produced in response to the growing recognition of the detrimental effects that domestic abuse has on society as a whole. It demonstrates the principle that domestic abuse and violence is unacceptable behaviour and that everyone has a right to live free from fear and abuse. It recognises the need to share information and work in partnership with other agencies with greater experience of domestic abuse in order to reduce the risk of harm to victims.

The National Health Service has a particular contribution to make in the drive to address domestic abuse. Guidance produced by the Department of Health (2005) and more recently in the NICE guidance (February 2014) has established domestic abuse as a major concern for all health care professionals and identifies the NHS as the one service that almost all victims of domestic abuse come into contact with regularly within their lifetime - either as the first or only point of contact with professionals.

Abused women are more likely to be in touch with health services than any other agency (Department of Health, 2005).

80% of women in a violent relationship seek help from health services at least once (Department of Health, 2000) and women suffering from the effects of domestic abuse typically make 7-8 visits to health professionals, either on their own or on someone else's behalf, before disclosure of abuse (Harris, 2002).

In addition, between 4% and 19.5% of women attending healthcare settings in England and Wales may have experienced domestic violence in the past year. A high proportion of women attending accident and emergency, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence at some point (Alhabib *et al.*, 2010; Feder *et al.*, 2009).

Between 30% and 60% of female psychiatric inpatients also report experiencing domestic violence in their lifetime (Howard *et al.*, 2010).

For women aged 19-44 years, domestic abuse is the leading cause of morbidity – greater than, cancer, war and motor vehicle accidents – and is the leading cause of injury and illness for girls and women aged 15-44 years. In the UK domestic abuse claims the lives of two women per week.

Violence and abuse can lead to increased risk of poor mental health, injuries, chronic physical conditions, unwanted and complicated pregnancy, sexually transmitted infections and substance misuse, and the effects can last a lifetime and into subsequent generations. Early intervention can reduce the impact of the many health consequences.

Domestic abuse is a key public health issue and treating related physical injuries and addressing mental health needs, costs the National Health Service in the region of £1.7 billion per annum (Walby, 2009).

Domestic abuse is a criminal act and a fundamental breach of trust and human rights, and contravenes an individual's right to feel safe, both within their home and within a personal relationship.

NHS Warwickshire North Clinical Commissioning Group (CCG) is committed to ensuring that victims of domestic abuse receive a high standard of care irrespective of age, race, culture, sexuality, religion or ability, and equality underpins all its service provision. It also recognises that perpetrators of domestic abuse may be service users.

The CCG recognises the serious adverse impacts that domestic abuse has on children who live in a violent, abusive household, and the short and long term damage to their physical and mental health. Within this context the CCG recognises its responsibilities to safeguard and protect children.

Domestic abuse is not only an issue for service users; there may also be a need to address domestic abuse issues for staff, male or female when they themselves may be current or past victims of domestic abuse, or are perpetrators of domestic abuse.

The Government has clearly identified the link between domestic abuse, poor health and impaired life chances. Some key national developments relating to this can be found in Appendix 3.

Key principles to help GPs develop a domestic abuse policy for their practices has recently been published (See 'Responding to Domestic Abuse': Guidance for General Practitioners http://www.rcgp.org.uk/policy/rcgp-policy-areas/domestic-violence.aspx).

National and local data can be found in Appendix 4.

2.0 Purpose

The purpose of this policy is to outline the requirements of CCG in supporting the prevention and detection of domestic abuse, specifically:

- That the CCG works in conjunction with partners and contracted providers to safeguard vulnerable individuals through the recognition of domestic abuse as a serious crime which has an adverse impact upon the health of individuals, families and communities.

- That the CCG ensures contracted providers have appropriate policies, procedures and training in place to facilitate early identification and management of domestic abuse in order to reduce the risk of harm.

- That the CCG informs its staff and member practices of best practice in respect of the recognition and management of domestic abuse in order to reduce the risk of harm.

- That the CCG ensures that processes are in place to monitor the implementation of action plans developed following a domestic homicide review, serious case review or individual management review.

3.0 Roles and Responsibilities

3.1 Governing Body

- To explicitly state the CCG's commitment to the early detection and prevention of domestic abuse;

- To ensure the CCG develops and implements a clear policy in respect of domestic abuse and communicates this to member practices and CCG staff;

- To ensure effective partnership working to support the reduction of domestic abuse.

3.2 Clinical Quality, Safety and Governance Committee

As the designated committee for safeguarding, is charged with:

- Receiving assurance reporting on the communication of the policy;
- Monitoring training of staff in the CCG and in commissioned providers;
- Providing scrutiny and challenge through the review of safeguarding and domestic homicide reports.

4.0 Definitions

A core definition has been adopted across Government Departments which defines domestic abuse as:

“Any incident of threatening behaviour, (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality” (Home Office, 2006).

It is a pattern of behaviour that is used to exert power and control over another person. It is acknowledged that domestic abuse can also manifest itself through the actions of immediate and extended family members with the perpetuation of unlawful activities, such as forced marriage, so called ‘honour crimes’ and female genital mutilation. Extended family members may condone or even share in the pattern of abuse. However, domestic abuse is a crime and is neither morally nor socially acceptable whichever form it takes.

The above definition has recently been reviewed by national Government to include 16-18 year olds within the definition.

5.0 Context
5.1 Who Might Experience Domestic Abuse?

A conservative estimate suggests that one in four women and one in six men will be a victim of domestic abuse in their lifetime (Home Office, 2003) and that 1 in 9 women presenting to health services at any one time will be currently living with abuse.

The majority of the most severe incidents and the most long standing abuse are most commonly experienced by women as the result of the actions of men.

Although the majority of domestic abuse incidents relate to male perpetrators and female victims, this is not always the case. Domestic abuse also affects the lesbian, gay, bi-sexual and transgender community as well as male victims.

Domestic abuse occurs among people of all income levels, ages and among people from all black, white and minority ethnic backgrounds. In terms of domestic abuse and ethnicity, British Crime Survey findings show little variation in the experience of inter-personal violence by ethnicity (Walby, 2004).

Domestic abuse is rarely a one-off incident, and should be seen as a pattern of abuse and controlling behaviour through which the abuser seeks power over their victim.

Factors associated with being a victim of domestic violence include:

- Long-term illness or disability (women and men with a long-term illness or disability are almost twice as likely to experience domestic violence as others).
- Use of any recreational drug in the last year.
- Marital status (married people had the lowest risk, while those who had previously been married had the highest risk).
- Age (women in younger age groups, in particular, in those aged 16–24 years are at greatest risk).

(All of the above are from: Home Office, 2011).

- Alcohol or drug consumption (partner assaults are four to eight times higher among people seeking treatment for substance-dependence) (Murphy and Ting, 2010).
- Pregnancy (the greatest risk is for teenage mothers and during the period just after a woman has given birth (Harrykissoon, 2002).
- Being lesbian, gay, bisexual or transgender (Barter *et al.*, 2009; Browne and Lim, 2008; Home Office, 2010b).

5.2 Children and Young People

The issue of children living with domestic abuse is now recognised as a matter of concern in its own right by both Government and key children's services agencies. The link between child abuse and domestic abuse is high with estimates ranging from 30%-66% depending upon the study. Therefore, whilst domestic abuse and child abuse do not always co-exist, it can be an important indicator of a child at risk of harm from either actual physical, sexual and/or emotional abuse or by exposure to abusive relationships.

The Adoption and Children Act (2002) extended the legal definition of harming children to include harm suffered by seeing or hearing ill treatment of others, especially in the home.

Living with domestic abuse can adversely affect all of the five outcomes for children identified in Every Child Matters (2004). In addressing the needs of children living with domestic abuse, it is important to be aware that children develop their own coping strategies; however, it is known that adverse experiences in childhood can detrimentally affect cognitive, psychological, physical, social and educational development. This may warrant long term involvement of health services.

At least 750,000 children and young people are estimated to be exposed to domestic violence every year in England (Department of Health, 2002). Approximately 75% of those living in households where domestic violence occurs are exposed to actual incidents (Royal College of Psychiatrists, 2004). Many will be traumatised by what they witness – whether it is the violence itself or the emotional and physical effects the behaviour has on someone else in the household (Department of Health, 2009). Domestic violence is also associated with an increased risk of abuse, deaths and serious injury for children and young people (Department of Health, 2009).

Domestic abuse often means that children live in an environment where there are high levels of physical punishment, misuse of power and authority and the generation of feelings of fear, anxiety and helplessness despite the best efforts of the non-abusive partner. Living with domestic abuse can cause distortion in children's perceptions of relationships, blame, cause and effect.

Recent studies suggest violence within adolescent relationships is increasing and there is increasing normalisation of violence within peer groups (NSPCC, 2009).

Parents can also be the victims of abuse perpetrated by a child or adolescent, although the proportion affected in England is unknown (Kennair and Mellor, 2007).

Domestic Abuse often begins or increases when a woman is pregnant. This presents an immediate need to safeguard the victim and the unborn child.

In OFSTED's biennial analysis of Serious Case Reviews (2009) the significance of the combined effect of domestic abuse, mental ill health and substance misuse (the 'toxic trio') as major contributory factors to children's deaths has been highlighted. These findings are reflected at a local level.

Statistics from the Forced Marriage Unit show that between January and May 2012, the unit dealt with 594 cases relating to possible forced marriage, 44% of which involved children under 18.

According to CPS statistics (2011), there are over 20 prosecutions every year for a range of offences including kidnap, imprisonment, assault and child sex offences where forced marriage has taken place.

The welfare of a child is paramount. In cases of suspected child abuse the duty of care that any health professional owes to a child or young person will take precedence over any obligation to the parent or adult carer. Living with or witnessing domestic abuse is now recognised as a source of significant harm to children and should be responded to by following the SWCCG safeguarding children Policy.

All Warwickshire health professionals must follow Warwickshire Safeguarding Children Board's Procedures www.wscb@warwickshire.gov.uk.

5.3 Vulnerable Adults

It is recognised that some victims of domestic abuse and forced marriage may face additional vulnerability factors and that these should be taken into consideration when offering help and support.

In England, 1.6% of older people (aged 66 years and over) reported experiencing abuse (psychological, physical, sexual and financial) in the past year from a family member, close friend or care worker (Department of Health, 2007). 40% of the abuse was perpetrated by a partner and 43% by another family member.

Women and men with a long-term illness or disability are almost twice as likely to experience domestic violence as others.

It has been recognised that individuals with learning disabilities are at risk in communities where forced marriage is prevalent.
http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/fm-disability-guidelines

All health professionals must follow the Warwickshire Safeguarding Adult Protection Policies www.wsab@warwickshire.gov.uk.

5.4 Potential Indicators of Domestic Abuse in Adults

Patients do not generally present with obvious physical injury (Campbell, 2002). Abuse can include threats, coercion and insults, as well as social and economic control. The patient may not recognise this is abuse. People are often reluctant to disclose abuse because of fear or shame, or because they think that they will not be believed.

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

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

5.5 Recognition of Domestic Abuse in Children

Whilst a child will respond differently to the abuse they have witnessed or experienced depending on their age, their personal resilience and support mechanisms, there is evidence that children suffer long term damage through living in a household where domestic abuse is taking place even though they themselves may not be directly harmed. Their emotional, physical and psychological development may be impaired.

Impact on the child or young person’s health can include:

- Physical injury e.g. broken bones and bruises.

- Death.
- Neurological complications.
- Premature birth, low birth weight and/or brain damage.
- Failure to thrive or weight loss.
- Stress related illness, asthma, bronchitis or skin conditions.
- Speech and language delays.
- Tiredness and sleep disturbance.
- General poor health.
- Enuresis or encopresis.
- Substance and alcohol misuse.
- Mental health issues such as depression and anxiety.
- Eating disorders.
- Damage following self harm.
- Teenage pregnancy.
- Low self esteem and self confidence.
- Behavioural and emotional disturbance.
- Introversion or withdrawal.
- Thoughts of suicide or running away.
- Post traumatic stress disorder.
- Anger, aggressive behaviour and delinquency.
- Assumes a parental role.
- Hyperactivity.
- Sexual problems or sexual precocity.
- Suicide attempts.
- Difficulty in making and sustaining friendships.
- Truancy and other difficulties at school.

(Improving Safety, Reducing Harm: Children, Young People and Domestic Violence. A Practical Toolkit for Front-Line Practitioners, Department of Health, 2009)

5.6 Potential Warning Signs or Indicators of Forced Marriage

A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is an appalling and indefensible practice and is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights.

The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.

Honour based violence (HBV) can be described as a collection of practices, as described above, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

From a Health perspective symptoms may include:

- Anxiety.
- Depression.
- Emotional withdrawal.
- Low self esteem.

- Accompanied to doctors or clinics.
- Self harm.
- Attempted suicide.
- Eating disorders.
- Isolation.
- Substance misuse.
- Early/unwanted pregnancy.

Whilst these factors may be an indication that someone is facing a forced marriage, it should not be assumed that it is forced marriage simply on the basis that someone presents with one or more of these warning signs. These warning signs may indicate other types of abuse that will also require a multi-agency response.

Less common warning signs have been experienced by practitioners such as:

- Cut or shaved hair (as a form of punishment for disobeying or, perhaps, 'dishonouring' her family).
- Girls reporting that they have been taken to the doctor's, to be examined to see if they are virgins.
- Women presenting with symptoms associated with poisoning.
- Female genital mutilation (FGM) before being able to marry; usually this will be performed during childhood but there have been reports of young girls or young women undergoing FGM just before a forced marriage.

For detailed guidance on health professionals' response to FGM go to:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_24551

For detailed guidance on a health professionals' response to forced marriage go to:
http://www.fco.gov.uk/resources/en/pdf/3849543/forced-marriage-guidelines09.pdf

GPs are encouraged to work to the best practice guidance attached as Appendix 5 following disclosure or recognition of signs of domestic abuse and/or forced marriage.

6.0 Domestic Homicide Reviews

Section 9 of the Domestic Violence, Crime and Victims Act 2004 introduced a statutory basis for local bodies to establish homicide reviews for victims of domestic violence. This provision creates an expectation that local areas should undertake a multi-agency review following a domestic violence homicide. The CCG will comply with this duty and will adhere to the guidance when participating in a review (see Safeguarding Vulnerable Adults Policy).

7.0 Training

Good practice would dictate that all members of staff and Governing Body members receive training on recognising and responding to domestic abuse. This is included in the training for Safeguarding Vulnerable Adults and Safeguarding Children Awareness (Levels 1 and 2).

The CCG will monitor training of its contracted providers and report training uptake on a bi-monthly basis to the Clinical Quality, Safety and Governance Committee.

WNCCG is statutorily required to provide training to primary care contractors; however, the CCG will source training uptake levels from NHSE and provide quarterly reports on the training uptake of its member practices to its Clinical Quality, Safety and Governance Committee.

8.0 Monitoring the Compliance and Effectiveness of this Policy

This policy will be routinely reviewed every three years. The Designated Leads for Safeguarding Children and Adults will provide quarterly reports outlining activities and developments on domestic abuse to the CCG's Governing Body through the Clinical Quality, Safety and Governance Committee. Should these highlight the need to amend the policy earlier; this will be recommended to the Committee.

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Appendix 1 Guidance to Doctors and GPs on the Release of Medical Records into a Domestic Homicide Review

Statutory Domestic Violence Homicide Reviews (also known as DHRs) were introduced under Section 9 of the Domestic Violence, Crime and Victims Act, 2004. The duty to undertake Domestic Homicide Reviews came into force on 13 April 2011.

What is a Domestic Homicide Review?

Domestic homicide reviews should be carried out when a person has been killed as a result of domestic violence (domestic homicide). A DHR is a multi-agency review aimed at learning lessons from the way agencies and individuals worked together in cases where someone is killed in circumstances of domestic abuse.

They are undertaken pursuant to 9(3) of the Domestic Violence, Crime and Victims Act (2004) and subsequent guidance. There is a requirement that agencies work together to produce a meaningful review. They are not "fault finding" exercises. That is the function of the Criminal and Coroners Courts. They are an enquiry into how people worked together in order to try and avoid such incidents arising in the future

In order for lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each homicide, and most importantly, to identify what needs to change in order to reduce the risk of such tragedies happening again.

How might the DHR impact on your work as a health professional?

All agencies, including GPs, have a statutory obligation to respond to requests for information when a DHR is underway. Each agency that has had contact with the victim, the 'perpetrator' or relevant family members will have to:

Secure records relating to the individual case against loss or interference. These records will be used to gain a chronology of events in relation to the organisation's involvement with the case.

Contribute to an Individual Management Review (IMR). A Senior Officer from each professional discipline e.g. police, GPs, social workers will be appointed to review the relevant agencies records, interview staff and prepare a report. They will not have had any previous involvement with the case and will be independent.

The report which is known as an Individual Management Review will allow the organisation to look openly and critically at individual and organisational practice and context within which people were working to establish if practice complied with organisational policies and procedures, and identify any lessons to be learned. It will also identify how changes to practice and procedure will be implemented and identify examples of good practice within the agency.

The IMRs are then collated by an Independent Author who will prepare an overview report bringing all the information together. The process is very similar to a Serious Case Review which follows when a child dies or suffers a significant injury from abuse or neglect.

Why are medical records required?

The records kept by any agency, including GPs and medics, form an important contemporaneous record of events which, when reviewed, can help tell the true story of how professionals were responding to the circumstances they were in and establish whether different ways of working could produce better outcomes in the future

Whose medical records might be required?

The records of the victim, his or her children and the alleged perpetrator may all be relevant to the review.

Not all the records will need to be accessed. Only records identified as relevant to the issues under review will need to be considered.

Do I need the consent of the patient?

No (see later). However, both courtesy and best practice says that it is normal to seek consent at the right time.

What is expected of the record holder?

As the record/document owner you will be provided with a short explanation of the key issues. The records should then be secured and these will be reviewed by an independent person to ascertain whether anything in them is relevant. If there is nothing relevant then the matter then ends.

If however relevant issues are identified in the records, they will seek consent to the records being disclosed to the IMR author. Once that consent is obtained the records will be forwarded on to the IMR author.

Can I release records if the patient's consent is refused?

Yes. The law and guidance is very clear that you can release the records even when the patient explicitly refuses consent. There are several legal "models" which govern the disclosure of records and information in these circumstances. They are briefly considered below, but they all add up to pretty much the same thing. If you reach conclusions using one legal route then the same thinking will probably apply to the others.

The Data Protection Act 1998 (DPA)

The DPA explicitly allows the release of confidential personal information, even where consent is refused, for "the prevention … of crime" (S 29). DHRs are explicitly intended to learn lessons to prevent homicides in the future and come squarely within this section.

In reaching a decision to release information under the DPA, the principles under the Act need to be applied. These are very similar to "Caldicott" principles with which you will be familiar. The main point is that only relevant and accurate information is shared for a specific and legitimate reason. The processes used in a DHR ensure this is achieved.

The Human Rights Act 1998 (HRA)

The HRA provides that individuals have a "Right to respect for private and family life" (Article 8). Decisions about the sharing of personal information and patient records would be covered by this. This is not an absolute right. Information and records can be shared without consent under Article 8 if doing so is lawful and necessary.

The "prevention of crime" is explicitly included as a legitimate ground for interfering with a right to respect for private life. Again, a common sense and proportionate approach needs to be taken: what information is actually relevant to the DHR? What do the terms of reference for the review actually require?

Providing information that answers the terms of reference is clearly lawful. It might be that there is also non relevant information, for example perhaps about a sexually transmitted disease treated many years earlier which would not be relevant and not need to be disclosed.

The Common Law and the General Medical Council (GMC) Guidance

The Common Law of England (Judge made law in court cases) has for many years also provided guidance and this is reflected in the GMC guidance which is helpful and concise.

The GMC advise

"36. … Confidential medical care is recognised in law as being in the public interest. However, there can also be a public interest in disclosing information: to protect individuals or society from risks of serious harm …"

Doctors sometimes think that only a real risk of physical harm justifies disclosure but this is not what the law says. This paragraph in the GMC guidance correctly sets out that protecting society from harm is also a legitimate reason to share information and this is just what a DHR sets out to do (c.f. the DPA and HRA "prevent crime" criteria).

The GMC go on to say

"37. Personal information may, therefore, be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential."

What the GMC guidance (just like the HRA and DPA) asks you to do is establish what is genuinely in need of sharing and then do so in a confidential and secure way as part of the DHR process. All of the different legal models simply require you to make a judgement about what the review genuinely requires. When you disclose information that you hold that answers the questions set out in the terms of reference then you will be complying with the law.

What do the GMC say?

"We … feel that there is a strong parallel with Serious Case Reviews. Our 0-18 years guidance for doctors (paragraph 62) says that doctors "should participate fully" in Serious Case Reviews; it goes on to say "When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent." We think it reasonable that this should be the principle that doctors should follow in cooperating with DHRs as well". Letter from GMC to Professor Pat Cantrill, Chair of Adult A DHR Sheffield, 6/10/11

Why bother asking for consent if it is not needed?

Firstly, it demonstrates a courtesy to the patient and shows that, whoever they are, you respect their rights and are taking their wishes and feelings into account. It also ensures that they feel they are involved in the DHR process; it is after all about them, even if they are the alleged perpetrator. This is why the GMC guidance tells you to do this.

What records should I disclose?

You need to review your records and see if there is anything that is relevant to the Terms of Reference (ToR) or any other information provided. If nothing is relevant then nothing should be disclosed. If there is something relevant (for example, consultations around mental health issues in the time period in the ToR, then that should be provided to the IMR author.

Who are the records disclosed to?

The records are only disclosed to the IMR author who will have a similar professional background to yourself and understand your professional issues. They will be kept securely. The IMR author will then review as part of their report writing process. The records will then be destroyed or returned to you if you wish. The actual DHR report will be based on the IMR reports prepared by each agency's author.

Is a Court Order required?

No. There are no court proceedings associated with a DHR so there is nothing for the Court to make an Order for. The responsibility for reviewing and disclosing records lies with each agency that holds them.

Will individuals or professionals be identified in the DHR?

No. Professional identities are anonymised e.g. HV 1 for a health visitor or GP 3 for a GP. Sensitivities around these issues can be communicated via your IMR author.

Will the DHR be made public?

Yes. This is a Government requirement.

When will the DHR be published?

While the preparation of the DHR can commence as soon as the homicide occurs, publication would usually wait until after any criminal process has concluded in order that any information that emerges through the trial process can be incorporated. There is always a dialogue with HM Coroner as to the timing of the report to establish whether the Coroner would also wish for publication to wait on any inquest. This can vary from case to case. The only time publication would happen before a criminal trial was if there was no prospect of a trial within a reasonable time frame, for example if the perpetrator was missing or is unknown.

Do I have to take the decision to release the records?

Yes. As the records owner the decision is yours. You need to make it in light of the guidance under the DPA, HRA and GMC above.

Who can I take advice from?

In the first instance you should feel at liberty to discuss any issues with your IMR author. They will have a similar professional background to you and understand the issues from your perspective. Similarly, the Independent DHR author can also be approached for advice.

For more information about the DHR process and to access useful resources please visit: http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/domestic-homicide-reviews/

Appendix 2 MARAC Briefing for Health Professionals

Multi-Agency Risk Assessment Conferences (MARACs) are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim. Over 250 MARACs are operating across England, Wales and Northern Ireland managing over 53,000 cases a year.

There are four MARAC meetings across Coventry and Warwickshire on a monthly basis, managing approximately 12-15 cases per meeting. Police and the following statutory and Voluntary Sector agencies are invited to attend:

- Health
- Mental Health
- Probation
- Women's Aid – IDVA (Independent Domestic Violence Advisor- who represents the victim and feeds back relevant information to the victim)
- Children's Services
- Adult Services
- Housing
- Education
- Drug/Alcohol services- Recovery partnership

Referral Process for Health Professionals

The criteria for referral to MARAC are listed below; health professionals can use the risk assessment (if they have received training,) or can seek assistance from the Health IDVA or Designated nurse for child protection - Warwickshire. The Named Nurses for all the provider organisations attend the MARAC.

Criteria for Referral to MARAC

Domestic Abuse victims are risk assessed using the CAADA/ DASH risk indicator checklist. The purpose of the DASH (Domestic Abuse, Stalking and 'Honour' based violence) checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. (DASH risk indicator checklists can be downloaded from:
http://www.caada.org.uk/dvservices/resources-for-domestic-abuse-practitioners.html)

If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

Recommended Referral Criteria to MARAC

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

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

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

If you are not referring a client into the MARAC, you may be asked to provide information to the MARAC (by the Safeguarding Named Nurses) which will assist in the information sharing process which is fundamental to the safety planning for the client.

What information would the MARAC want from a health professional?

The information you provide will differ depending on where you work within the Health economy and the relationship you have with the client, the perpetrator and/or members of the family.

Information provided will always include basic details such as names and dates of birth.

Below are some examples of information that could be provided to the MARAC from specific health professionals.

Health Visitors: information about recent visits/contact, check of contact details, your professional opinion on the general health and development of children and mother, recent attitudes/behaviours, what you perceive to be the risks and possible protective factors.

A&E Staff: relevant and basic details on the patient and the services they required that might relate to the domestic abuse. This could include dates of attendances at A&E, summary of injuries sustained, whether domestic violence was disclosed, who attended and what relevant services have been accessed. This can highlight the severity of abuse to other agencies.

The Ambulance Service: relevant and basic details on the patient and the services they required that might relate to the domestic abuse. This could include dates of attendances to the patient by the Ambulance Service and any transportation to A&E required, summary of injuries sustained, whether domestic violence was disclosed and who was with the patient at the time of the attendance by Ambulance Service. This can highlight the severity of abuse to other agencies and potentially help identify all members of a household.

Mental Health: relevant information relating to the safety of the victim/children and the risk management of the perpetrator. This could include details around what services the victim/perpetrator/children are receiving, whether your agency has capacity to take on service users if there is a need, and information on the history of mental health issues.

All health agencies can also support the MARAC process with specific actions. For example, you may be able to provide access to the victim for support services, advise staff on whether home visits are appropriate, or you may be able to gain access to a woman without presence of partner/family members. You may be able to ensure that the response to the patient in future reflects the fact that they are a high risk victim of domestic abuse, that any further incidents would prompt an enquiry into their cause and a possible referral to the appropriate person/agency.

Mental health services may be able to offer services to victims/perpetrators and children if the service is appropriate and required.

Both Coventry and Warwickshire have their own MARAC Operating Protocol and MARAC Information Sharing Protocol.

For detailed guidance about appropriate information sharing in relation to MARACs and Health agencies, please see:

'Striking the Balance' Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Department of Health and UK Council of Caldicott Guardians, April 2012).

http://www.dh.gov.uk/health/2012/04/striking-the-balance-guidance-on-information-sharing/

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133589

Appendix 3 Relevant Government Legislation, Strategies and Guidance

The Children Act (1989) which underpins Every Child Matters (2004) and provides a legal framework in respect of safeguarding children and young people.

The Crime and Disorder Act (1998) which gave Primary Care Trusts a statutory duty to work within Crime and Disorder Reduction Partnerships to reduce local crime including domestic abuse.

Domestic Violence, Crime and Victims Act (2004). Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of this Act (April 2011).

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office, 2011) provides detailed guidance for the delivery of these reviews.

Call to End Violence Against Women And Girls: Strategy (HM Government, 2010) and Action Plan (HM Government, 2011). This cross-Government strategy and plan sets out a coordinated approach to ending violence against women and girls. It includes a range of actions for the police, councils, NHS and Government departments across three areas: prevention, provision and protection.

Improving Services for Women and Child Victims of Violence: Action Plan (Department of Health, 2010).

Responding to Domestic Abuse; A Handbook for Health Professionals (Department of Health, 2005) provides a practical toolkit for individuals working within healthcare settings, and is supported by Improving safety, Reducing Harm; Children, Young People and Domestic Violence (2009).

Multi-Agency Practice Guidelines; Handling cases of Forced Marriage, have been developed by The Forced Marriage Unit to supplement the statutory guidance.

“The Right to Choose” issued under s63 (Q) 1 Forced Marriage (Civil Protection) Act 2007. The practice guidelines provide advice and support for frontline practitioners who have responsibilities to safeguard children and protect adults from the abuse associated with forced marriage.

Forced Marriage and Learning Disabilities: Multi-Agency Practice Guidelines (FMU, 2010).

Female Genital Mutilation Act (2003)

Female Genital Mutilation: Multi-Agency Practice Guidelines (HM Government, 2011)

Safeguarding Adults: The Role of Health Services (Department of Health, 2011)

The National Institute for Health and Clinical Excellence (NICE) Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (2014)

Multi-agency working is widely accepted as the best way to approach domestic abuse and is strongly recommended by local and central government for all cases of domestic abuse.

Multi-Agency Risk Assessment Conferences (MARACs) provide an opportunity to share information about high risk domestic abuse cases and implement a multi-agency response in order to reduce risk and promote safety of the woman and any children within the family.

‘Striking The Balance’ MARAC and Caldicott Guardian guidance for sharing information at MARAC (2012).

Royal College of Midwives (2006) Domestic Abuse in Pregnancy. Position Paper, London.

NICE Pregnancy and Complex Social factors (2010).

Saving Mothers' Lives: Reviewing maternal deaths to make motherhood.

Safer 2006–08. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. Centre for Maternal and Child Enquiries (2011).

Appendix 4 Best Practice Guidance for GPs

Health Service staff have a particular contribution to make because the NHS is the one service that almost all victims of domestic abuse will come into contact with at some point in their lives. All health care professionals who have contact with patients/clients need to be aware of the risks of all forms of domestic abuse and be alert to the possible indicators that it is taking place. The CCG will work to ensure that all contracted providers adhere to the procedures detailed below.

Responding to the patient/client following disclosure or recognition of signs of domestic abuse and/or forced marriage

General practitioners are the major professional group to whom people experiencing domestic abuse turn (Hegarty and Taft, 2001). Responding effectively in a medical setting requires non-judgemental, supportive attitudes, a knowledge of the physical and emotional impact of the abuse, an understanding of appropriate and inappropriate responses, and on having a good understanding of local domestic abuse care pathways. General practitioners can access specific guidance from: http://www.rcgp.org.uk/policy/rcgp-policy-areas/domestic-violence.aspx

Although forced marriage shares significant similarities to domestic abuse (and often domestic abuse occurs in relationships where there has been forced marriage), it is also different to domestic abuse in that there are often multiple perpetrators who can be members of the same family or members of a community. Therefore there are additional factors to bear in mind when responding to forced marriage situation.

If a patient has disclosed domestic abuse or forced marriage, let the patient tell you their story.

The patient may not have disclosed that they are experiencing domestic abuse or are being forced or have been forced into marriage, but you may suspect that this is happening to them because of some of the critical indicators (see 5.4, 5.5 and 5.6).

Asking appropriate questions

If you need to, ask the patient for more information to help you to assess the situation and gather as much information as possible. Evidence suggests that women who are being subjected to violence want to be asked, and that women who are not, do not mind being asked (Friedman *et al.,* 1992). It is important to ask direct questions in a gentle, non-threatening manner (Schei, 1989). A suggested opening for selective enquiries might be:

“I am sorry if someone has already asked you about this, and I don’t wish to cause you any offence, but we know that throughout the country 1 in 4 women and 1 in 7 men experience domestic abuse at home and sometime in their life. I noticed that you have a number of bruises/cuts/burns (whatever) - it is routine for health care staff to ask about domestic abuse in these situations.”

Further suggested questions are:

- You seem very anxious and nervous. Is everything alright at home?
- Does your partner get jealous of you seeing friends, talking to other people or of you going out? If so, what happens?
- You seem frightened of your partner. Has he/she ever hurt you?
- When I see injuries like this I wonder if someone could have hurt you.
- Many patients tell me they have been hurt by someone close to them.
- Could this be happening to you? Are you afraid of your partner or a family member?
- Has your partner or anyone else at home, threatened you?
- You mention your partner loses his/her temper with the children. Does he/she ever lose their temper with you? What happens when they lose their temper?

- Have you ever been in a relationship where you have been hit, punched, kicked or hurt in any way? Are you in such a relationship now?
- You mentioned your partner uses drugs/alcohol. How does he/she act when drinking or on drugs?
- Does your partner sometimes try to put you down or control your actions?
- Sometimes, when others are over-protective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?
- Your partner seems very concerned and anxious. That can mean he/she feels guilty. Was he/she responsible for your injuries?
- Would you like support?
- I think that there's a link between your (insert illness) and the way your partner treats you. What do you think?

The patient's answers to these questions will help you to assess the possible risks to their safety and that of their children.

'Golden Rules'

Before you begin to ask any questions, be aware of the following 'Golden rules':

- Any interview should be undertaken in a suitable environment which does not include the perpetrator or any inappropriate person and respects the client's entitlement to privacy and dignity.
- Staff should never ask about possible abuse in the presence of the partner, children or other family members.
- Where the victim does not speak English it is essential that an interpreter is used to obtain a direct history from the victim. In no circumstances should a family member be asked to interpret.
- It is important when asking the client direct questions about their experience to do this sensitively and in a manner that is empathetic and supportive.
- Ask direct questions rather than letting an improbable explanation pass without saying anything.
- Listen carefully. The person may talk around the subject before disclosing to you. Requests for help are often veiled and may 'hide' behind other things. Think about ways in which you could draw out further information.
- Respect confidentiality and privacy – also understand the need to share information if immediate protection is required for either the adult or the children.
- Respect and validate what they tell you and remember that you may be the first person who has listened to them and taken them seriously. Tell them that you believe them.
- Emphasise the unacceptability of violence.
- Do Not suggest that they are responsible for the violence.
- Ensure the safety of the abused and any dependent children/vulnerable adults.
- Seek to empower - do not try to make decisions on their behalf.
- Know how to ask the right questions to let your patient know they can talk about domestic abuse.

Where forced marriage is an issue:

- Reassure them about confidentiality i.e. practitioners will not inform their family

Do Not

- Send them away.
- Approach members of their family or community unless they expressly ask you to do so.

- Share information with anyone without their express consent.
- Breach confidentiality.
- Attempt to be a mediator.

Ensure that you do not place yourself or colleagues at risk in a potentially violent situation.

Immediate action following disclosure or indicators of potential domestic abuse/forced marriage

Following disclosure or identification of domestic abuse and/or forced marriage, the client/patient may be open to support or advice or alternatively may refuse to discuss the situation. Regardless of their response, as a health professional you need to do the following:

- If the patient/client is under 18 years of age, or is pregnant or has children then Warwickshire Safeguarding Children Board procedures need to be followed. www.wscb.warwickshire.gov.uk.

- If the patient/client is a vulnerable adult (over 18 years of age, in need of community care because of a disability, mental health, age or illness or unable to protect themselves against significant harm/exploitation) Warwickshire Safeguarding Adults Board Safeguarding Adult procedures and Practice Guidance need to be followed www.wsab.warwickshire.gov.uk

- Immediate response to physical injuries may be required, and referral for further assessment, treatment, specialist advice or counselling.

- Consider immediate risks e.g. whether they are in immediate danger of serious injury or death. If so, contact the police using 999.

- Health care professionals also need to take into account their own safety and that of their colleagues, and must minimize the risks that they may face from the perpetrator of domestic abuse who may well be a patient/client.

In situations where forced marriage is suspected or disclosed in addition to the above points ensure that you:

- Contact, as soon as possible, a trained specialist who has responsibility for forced marriage (e.g. The Safeguarding lead).

- Refer them to the Forced Marriage Unit (http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/information-for-victims).

- Obtain full details to pass on to trained specialist.

- Explain all the options to them and ensure that she/he can get information in a language and format that is suitable to their needs.

- Consider the need for immediate protection and placement away from the family.

- Establish a way of contacting them discreetly in the future.

Offer them a further appointment; a health appointment may be one of the few occasions where they are allowed out of the house and having an appointment card can give them a legitimate excuse and provide them with an opportunity for getting further help.

Risk Assessment

Once immediate needs are met – or during that process, an assessment of safety should be undertaken. If you need to seek advice in relation to this assessment contact:

- CCG Safeguarding team on 02476 246019
- Designated nurse for Warwickshire on 07909686106

A risk assessment should address:

1. History of abuse. Is there an increase in intensity, frequency and severity?

2. Is the abuser:

    - Making verbal threats?
    - Frightening/disturbing/threatening friends and neighbours?
    - Threatening to harm or abduct the children?
    - Actually harming the children?
    - Frequently intoxicated (drugs/alcohol) and more violent when in this state?
    - Threatening suicide or self-harm?
    - Experiencing mental health problems?

3. Woman's current fear of the situation, and beliefs about the immediate danger.

4. Self-harm or attempted suicide by the abused person.

5. Attempts to get help (e.g. from police, courts, refuges etc.) during past 12 months.

6. Availability of support (e.g. friends, family).

7. Availability of a 'safe haven' if they do not wish to return home. Consider the woman's own preferences and the increased risk if a victim leaves the perpetrator.

8. Identification of stalking, forced marriage and/or 'honour'-based violence.

A detailed Domestic Abuse, Stalking and 'Honour'-Based Violence Risk Assessment Tool (DASH) can be used by health professionals who have received the training http://www.caada.org.uk/dvservices/resources-for-domestic-abuse-practitioners.html.

Once a risk assessment has been undertaken (either by you or an IDVA), the patient's situation will be assessed as either standard, medium or high risk.

If, following a risk assessment, the person is assessed as high risk or they are over 18 and facing a forced marriage situation, they can be referred into Warwickshire's Multi Agency Risk Assessment Conference (MARAC) through the IDVA or direct referral.

The MARAC meeting ensures that relevant information is shared and additional safety measures are put in place for the victim and any children.

A MARAC briefing for Warwickshire health professionals can be found at Appendix 2.

Cases which fall below the MARAC threshold can still be offered the support of the Health IDVA who will provide safety planning, legal advice and referral to appropriate agencies.

The risk assessment should indicate if the patient is safe to go home. If they are not, ensure that you have referred to the IDVA and/or the Police.

The potential risks to any children will be assessed by a multi-agency team using the Barnardos Risk Indicator Tool and information will be shared where appropriate with relevant professionals, and relevant support be put in place where appropriate. The Domestic Abuse Lead Nurse participates in this risk assessment process.

Providing Information and Signposting

If they are safe to go home, offer ongoing support and inter-agency liaison and provide information about where he/she can go for help and how to contact local services

It is not the responsibility of the health care professional to instruct someone experiencing domestic abuse on what action they should take.

Information Sharing

The client's confidentiality should be emphasised.

However, the victim must be reminded of the practitioners need to share information if there are children or vulnerable adults in the household as a multi-agency response may be necessary, or where the risk to the victim is assessed as high risk and the case will therefore be referred to a Multi-Agency Risk Assessment Conference (MARAC). For information about sharing information in MARAC cases please see Appendix 2 and 'Striking a Balance'
http://www.dh.gov.uk/health/2012/04/striking-the-balance-guidance-on-information-sharing

Where dealing with a forced marriage situation information must be shared on a strictly need to know basis as the situation may be complex and extremely dangerous for the victim.

Someone facing forced marriage may be concerned that if confidentiality is breached and their family finds out that they have sought help they will be in serious danger. On the other hand, those facing forced marriage are often already facing serious danger because of domestic abuse, "honour-based" violence, rape, imprisonment etc. Therefore, in order to protect them, it may be necessary to share information with other agencies such as the police.

Consequently, confidentiality and information sharing are going to be extremely important for anyone threatened with, or already in, a forced marriage. Practitioners need to be clear about when confidentiality can be promised and when information may need to be shared.

Seek advice from a domestic violence co-ordinator/safeguarding children's lead/MARAC co-ordinator on how to share information with practitioners from other agencies.

There may be occasions when the person's family members ask a third party e.g. a family friend, councillor, MP or those with influence within the community to request information from practitioners. The third party may have been given a very plausible reason by the family for needing to know the whereabouts of the person e.g. the illness of a close relative, and the third party may unwittingly think they are helping them. These requests are often made by telephone and rely on the person making the request persuading a practitioner that they are authorised to receive information. Do not share this information.

Record Keeping

The Department of Health state that 'documentation and record keeping have an important role in responding to domestic violence'. Each department/service should consider the need for recording information and the value of monitoring data in order to reinforce good practice.

Staff should clearly explain to the victim the importance of documenting their experience. Records of injuries may prove vital at a later date if they choose to prosecute the abuser. Additionally, clear and concise documentation of their abuse is a helpful way of validating their experiences and demonstrates that you have taken seriously their account of events.

However, extreme caution should be taken when documenting domestic abuse in order to maintain confidentiality.

Any work done around safety planning should be clearly documented in the clinical notes to enable staff to follow up at a later date.

Staff must ensure that medical records are well documented for the purposes of monitoring the client/patient's care and incidences of abuse/suspected abuse.

Disclosure or suspicion of domestic abuse should never be recorded in client or patient held records and staff should be vigilant in ensuring that records are not left unattended as this could place the abused person in serious danger.

Working with domestic abuse when both partners are your patients or within the same practice

- The needs of both patients should be addressed independently.
- When abuse is suspected or confirmed, both parties should be seen without the other being present.
- Affirm to the abused person that their health and safety are important and that confidentiality will be protected, unless disclosure is required by law.
- There should be no discussion about the suspected or confirmed abuse with the alleged abuser unless the woman consents to it.
- If a patient agrees to the general practitioner contacting the alleged abuser it is important that a safety plan is in place.
- It is not a conflict of interest to ask a patient about the possibility of abuse or to have an active management plan when it is suspected or confirmed if the alleged abuser is also a patient.

Have in place staff protocols that ensure confidentiality of records.

Support for Employees experiencing Domestic Abuse/Forced Marriage

Domestic abuse is not only a service delivery issue. It affects all sections of society and the CCG recognises the need to have clear and effective responses to help minimise the impact of domestic abuse upon employees. Domestic abuse can affect work performance and the health and safety of employees.

Staff offering support to work colleagues should follow the same basic principles and practices outlined in this policy and recommend referral to a staff support service and/or domestic abuse specialist service.

Appendix 5 Local and National Contacts

Domestic Abuse Services in Warwickshire

Warwickshire Against Domestic Abuse: www.talk2someone.org.uk

Services for Victims[1]

Domestic Abuse Support Service:

Stonham (part of Home Group) deliver open access, advice and information for anyone concerned about domestic abuse via a specialist helpline, website and drop in sessions. **All services can be accessed through the helpline number.**

Drop In clinics are delivered across the county; please contact the service for further details.

Specific services include:

Specialist domestic abuse helpline: Free phone 0800 408 1552
Mon – Fri 09:00 – 21:00
Sat 08:00 – 16:00

Referrals line for professionals: 0845 155 0376
Mon – Fri 09:00 – 17:00
This number can also be used for contacting the MARAC Co-Ordinator

Housing related floating support
Housing related floating support develops and sustains a service user's capacity to live independently in their accommodation. As well as supporting victims in relation to their accommodation the service offers support with many other aspects including:

- Personal safety and security
- Finances, bills etc..
- Education, training and employment
- Health and wellbeing
- Social skills, networks, activities etc…

Specialist support for:

- **Male victims**
- **Black and Minority Ethnic communities**
- **Lesbian Gay Bisexual and Transgender victims**

Sanctuary Scheme
The Sanctuary Scheme provides support to help victims to remain living safely in their own homes once they have ended their relationship, including the installation of home security measures. The project is for all female and male victims of domestic violence and abuse aged from 16 who are living in any type of property within Warwickshire. The project accepts both self-referrals and referrals from any agency.

WCC funded domestic abuse services in Warwickshire have been re-commissioned with new providers in place as of April 2012.

Independent Domestic Violence Advisors (IDVAs)
The IDVAs provide support to high risk victims of domestic violence and abuse. They work with the victim to develop an intensive risk management plan and ensure they are receiving all the support required to keep themselves and their families safe. They also offer support to clients who are accessing the criminal justice system and need support during criminal or civil legal proceedings. The IDVAs can provide support during court hearings, act as an advocate and refer victims to a range of other specialist agencies and support. IDVAs are available for all high risk female and male victims of domestic violence and abuse aged from 16 and accepts both self-referrals and referrals from any agency

Multi-Agency Risk Assessment Conference coordination
Multi-Agency Risk Assessment Conferences (MARACs) are multi-agency meetings which focus on the safety plan of high risk victims of domestic abuse. Professionals concerned that a victim of domestic violence and abuse may be at a high level of risk of harm can refer cases to the MARAC Co-ordinator.

Freedom Programme & Drop In Sessions - Please contact Stonham for further details.

Services provided by the DASS are available to victims at any level of risk, apart from the IDVA Service which is only for victims assessed as being at a high risk of harm.

Domestic Abuse Refuge Service

Refuges provide safe emergency housing and support to women (aged 16 and over) and their children escaping domestic violence and abuse. Addresses are confidential.

Leamington: 01926 832 861	9am – 5pm
Nuneaton: 02476 388 093	9am – 5pm
Rugby: 01788 571 589	9am – 5pm

Out of hours contact: 07584 233 473.

Domestic Abuse Counselling Service (DACS)

DACS is committed to the protection of women and children by providing therapy for victims and perpetrators of abuse to enable them to make the changes they need to make in their life.

Email: enquiries@dacservice.org.uk

Website: http://www.dacservice.org.uk

Tel: 0845 0044075

Address: CVS House, 72 High Street, Nuneaton, Warwickshire, CV11 5DA.

Blue Sky Centre (Sexual Assault Referral Centre)

The Blue Sky Centre is a Sexual Assault Referral Centre (SARC) for women, men and children; it recognises all forms of sexual violence including: Rape, Sexual Assault, Childhood Sexual Abuse, Rape within marriage, Female Genital Mutilation, Trafficking and Sexual Exploitation.

What is a SARC?

A Sexual Assault Referral Centre is a single location where any victim of Rape or Serious Assault will receive medical care, police intervention (if you choose to report the crime) and various other support services. A SARC is an independent service that can operate 24/7 to assist all victims of Rape and Sexual Assault. Our SARC is a local partnership between the police, health services and voluntary organisations set up to focus on your immediate support needs.

The Blue Sky Centre offers the following services:

- Dedicated forensically secure facility integrated with hospital services.
- Availability of forensic examination 24 hours a day within 4 hours of immediate need.
- Self referrals can be made.
- Forensic Results can be stored.
- A female medical practitioner wherever possible.
- Crisis workers available to provide immediate support to the victim.
- Immediate access to emergency contraception and drugs to prevent sexually transmitted diseases and HIV.
- Referral pathways to Independent Sexual Violence Advisors.
- Signposting and referral to other appropriate statutory and voluntary services.

Opening Hours:

The SARC will usually be staffed during normal working hours but will be available for use via a call-out system on a 24/7 basis 365 days of the year.

Contacting the SARC:

The SARC telephone number is **02476 865505.** You can call and discuss the circumstances with us and we will advise you about the most appropriate next steps which may be an appointment at the SARC for a forensic examination or a referral to other services that can help you.
Whilst anyone can attend the Centre without an appointment we would not be able to see people immediately if both wings are already in use, so prior contact is recommended by calling us.

The Blue Sky Centre is located on the site of George Eliot Hospital in Nuneaton.

Rape or Sexual Abuse Support Project (RoSA)

Confidential support for Survivors of rape or sexual abuse, men & women, individual & group support. Support for young survivors from the age of 13 years.

24 hour confidential answerphone.
Tel 01788 551151

Address: P.O. Box 151, Rugby, Postcode CV21 3WR

Email rosa.support@btconnect.com

Website: http://www.survivorguide.co.uk/

Safeline

Safeline Warwickshire - is a leading specialist independent charity providing support to survivors and their families of sexual abuse and rape across Warwickshire and surrounding areas. Males and females, young and older, from diverse communities can access a range of provision including free phone telephone helpline, 121 counselling/psychological sessions, support groups, ISVA, training, CAF, APE, young people and schools projects.
For the full range of services refer to – www.safeline.org.uk

Safeline free phone helpline number: 0300 123 2028
Monday to Friday, 7:30pm to 9:30pm.

Email: office@safeline.org.uk
Postal address: Safeline, 6a New Street, Warwick CV34 4RX
Office Telephone No.: 01926 402 498

Services for Children and Young People

Victim Support Domestic Violence and Relationship Abuse Project

The DV RAP provides direct support to children and young people who are affected by domestic abuse or are in / at risk of abusive relationships themselves. The project works with children and young people aged between 4 and 18 years old (up to 25 for disabled young people) who have experienced domestic abuse, either through living in households where there is domestic abuse or are experiencing abuse in their own relationship.

The project provides:

- One to one confidential support,
- Group work activities,
- Awareness raising work in schools and youth settings,
- Work with the family and wider agencies to affect positive change.

The project accepts referrals from:

- Any professional working with a family with the agreed paperwork completed, and that meets the referral criteria.
- Any child or parent

The project works in co-operation with the family and therefore all referral agencies must have consent from the child/ young person and non-abusing parent before referral. If there are difficulties with consent, please contact the manager to discuss possible solutions.

If you have any questions or queries about making a referral to the DVRAP please call Nicola Hall, DV RAP locality Project Manager
Tel: 01926 682687 or
Email: relationshipabuse.cyp@victimsupport.cjsm.net

Services for Perpetrators

Domestic Abuse Counselling Service (DACS)

DACS is committed to the protection of women and children by providing therapy for victims and perpetrators of abuse to enable them to make the changes they need to make in their life.

Tel: 0845 0044075

Address: CVS House, 72 High Street, Nuneaton, Warwickshire, CV11 5DA.

Email: enquiries@dacservice.org.uk

Website: http://www.dacservice.org.uk

Other Useful Services

Citizen's Advice Bureau
Citizens Advice Bureau offer free, confidential, impartial and independent advice from many locations in Warwickshire. Our advice helps people resolve their problems with debt, benefits, employment, housing, discrimination, and many more issues. It is available to everyone. Advice may be given face-to-face or by phone. Most bureau can arrange home visits and some also provide email advice. A growing number are piloting the use of text, online chat and webcams.
Search for your local bureau to see the full range of services it provides:
http://www.citizensadvice.org.uk/index/getadvice.htm

Local Authority Housing Teams:

- **North Warwickshire Borough Council - Tel 01827 715341**
  Website: http://www.northwarks.gov.uk/housing
- **Nuneaton and Bedworth Borough Council – Tel 0247 7637 6376**
  Website: http://www.nuneatonandbedworth.gov.uk/housing
- **Rugby Borough Council – Tel 01788 533 533**
  Website: http://www.rugby.gov.uk/housing
- **Stratford-on-Avon District Council - Tel 01789 267575**
  Website: http://www.stratford.gov.uk/community/community-113.cfm
- **Warwick District Council – Tel 01926 450000**
  Website: http://www.warwickdc.gov.uk/WDC/Housing/default.htm

National Services: Victims

National Domestic Violence Helpline - Tel: 0808 2000 247 – 24 hours a day
The Freephone 24 Hour National Domestic Violence Helpline, run in partnership between Women's Aid and Refuge, is a national service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf.

Forced Marriage Helpline - Tel: 0800 5999 247 Mon – Fri 9.30am – 5pm
Called the 'Honour Network', the dedicated helpline is run by the charity Karma Nirvana, which helps survivors of honour crimes and forced marriages

Broken Rainbow - Tel: 0845 260 4460 Monday to Friday 9am to 1pm and 2pm to 5pm
For lesbian, gay, bisexual & transgender people who experience domestic violence

Men's Advice Line - Tel: 0808 801 0327 Monday - Friday 10am- 1pm and 2pm - 5pm
A helpline for male victims of domestic violence and abuse

National Services: Perpetrators
Respect - Tel: 0845 122 8609 Monday - Friday 10am - 1pm and 2pm - 5pm
A helpline offering information and advice to people who are abusive towards their partners and want help to stop
http://www.respectphoneline.org.uk/phoneline.php

Everyman Project - **Tel: 0207 263 8884**
Everyman offers a range of support services for men who want to stop behaving violently or abusively, and for the people affected by their violence or abuse.
http://www.everymanproject.co.uk/

National Services: Children

Childline - Tel: 0800 1111 – 24 hours a day
ChildLine is the free helpline for children and young people in the UK who want to talk about any problem.

www.thehideout.org.uk
A website for children and young people living with Domestic Violence and Abuse:

http://thisisabuse.direct.gov.uk/
A website for children and young people living with Domestic Violence and Abuse:

Warwickshire North Clinical Commissioning Group: Equality Impact Assessment

Appendix 6

Department	Quality	Name of person completing EIA	Jackie Channell
Date of EIA	10.02.15	Accountable CCG Lead	Jacqueline Barnes
		CCG Sign off and date	

Piece of work being assessed: Domestic abuse policy

Aims of this piece of work: To offer a comprehensive guidance to all CCG staff and partners to raise awareness and tackle the issue of domestic abuse.

Other partners/stakeholders involved: All CCG staff and Primary care staff

Who will be affected by this piece of work? All WNCCG staff and stakeholders

Single Equality Scheme Strand	**Baseline data and research on the population that this piece of work will affect.** What is available? Eg population data, service user data. What does it show? Are there any gaps? Use both quantitative data and qualitative data where possible. **Include consultation with service users wherever possible**	**Is there likely to be a differential impact?** Yes, no, unknown.
Gender		no
Race		no
Disability		no
Religion/ belief		no
Sexual orientation		no
Age		no
Social deprivation		no
Carers		no
Other		

Equality Impact Assessment Action Plan

			←	CCG	→
Strand	**Issue**	**Suggested action(s)**	**How will you measure the outcome/impact**	**Timescale**	**Lead**