Policy:

NP 015 Domestic Abuse

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Policy Owner	Adult Safeguarding Advisor and Head of Safeguarding
Policy Author	Adult Safeguarding Advisor and Head of Safeguarding

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Summary of policy The policy outlines the roles and responsibilities of all staff

Target audience	This policy applies to all SHSC staff whether employed within full time, part-time, bank or fixed term contracts irrespective of their length of service. The policy also applies to volunteers and contractors working with SHSC service users

Keywords	Domestic Abuse, Honour Based Abuse, Forced Marriage, Safeguarding, MARAC

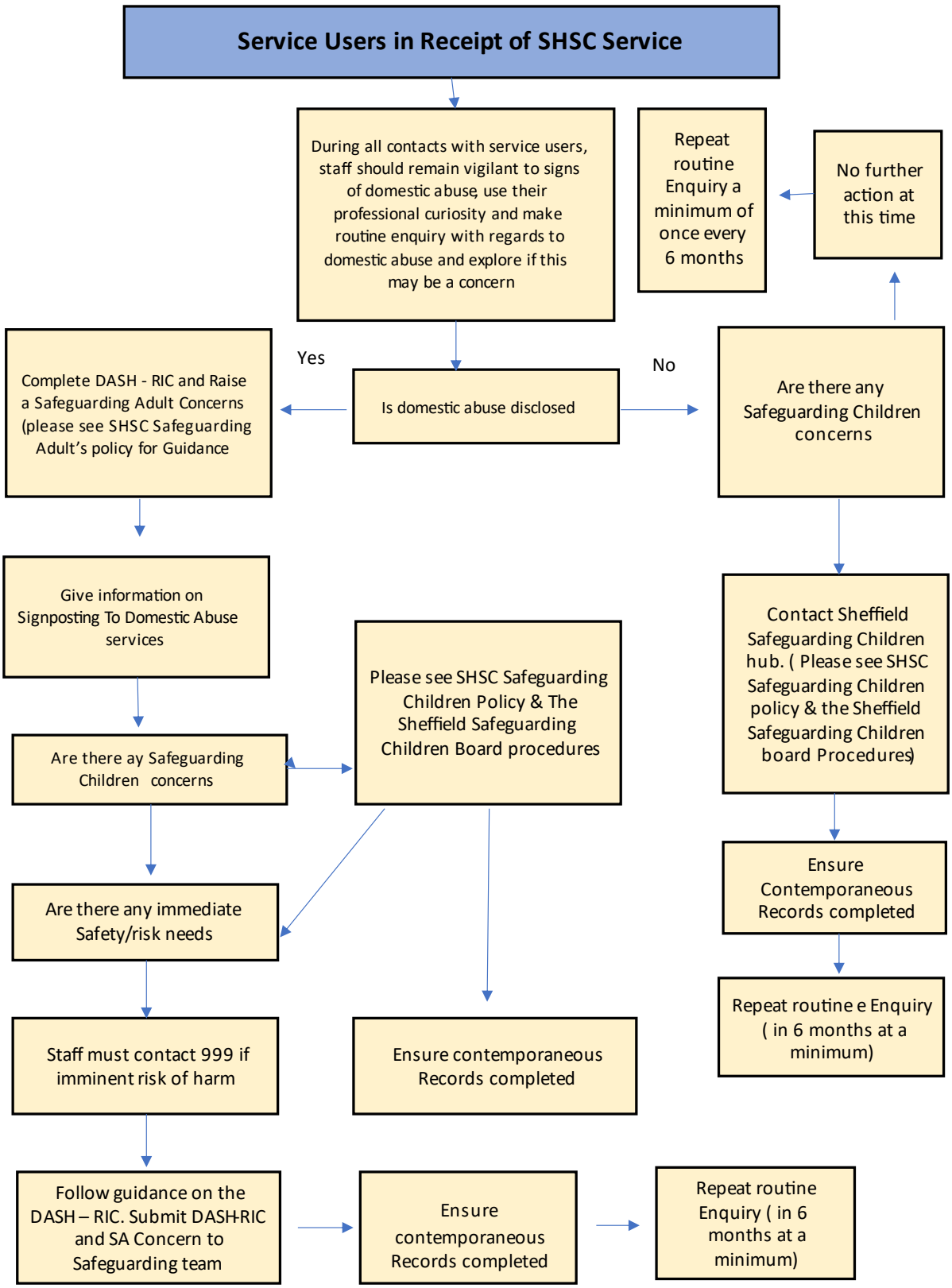
Storage & Version Control Version 7 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V6 April 2022). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Policy Version and advice on document history, availability and storage Policy version and advice on availability and storage version 6
Version 6 (April 2022)
Version 5 (June 2019)
Version 4 (December 2015)
Version 3 (October 2014)
Version 2 (December 2013) Available on Policy website and Internet.
Archive stored by Risk Management Department
The policy is for all staff to follow in assisting them in identifying Domestic Abuse and signposting service users to other services including those for high risk Domestic Abuse. (Multi Agency Risk Assessment Conference – MARAC)

Contents

Appendix 1 all staff process for disclosure of domestic abuse



1. Introduction

1.1 Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) are committed to ensuring that people who are or may be in need of support from our services are protected from abuse.

1.2 Through the introduction of the Domestic Abuse Act 2021, the UK the government aims to:

- Raise awareness and understanding about the devastating impact of domestic abuse on victims and their families
- Further improve the effectiveness of the justice system in providing protection for victims of domestic abuse and bringing perpetrators to justice
- Strengthen the support for victims of abuse by statutory agencies

Domestic abuse was described the Minister for Safeguarding as an “abhorrent crime perpetrated on victims and their families by those who should love and care for them.” Those who experience domestic abuse are at a considerable health disadvantage and may be at life threatening risk. In the year ending March 2020, an estimated 2.3 million adults aged 16 to 74 years experienced domestic abuse in the last year (1.6 million women and 757,000 men) and more than one in ten of all offences recorded by the police are domestic abuse related.

1.3 This policy offers a framework for good practice for health and social care staff to recognise, respond and challenge domestic abuse. The policy is intended to ensure that SHSC staff make routine enquiries around domestic abuse and provide access and information to empower people to make informed choices about their safety and lifestyle to emphasise that child protection and safeguarding adult needs are at the core of that agenda.

1.4 Appendix 1 provides an easy-to-use flow chart for staff to utilise when considering the assessment of any person referred to SHSCFT services.

2. Scope

2.1 This is a Trust wide policy which supports SHSCFT staff in implementing and understanding the Department of Health Guidance, Responding to domestic abuse – a handbook for Health Professionals (2017) and guides staff as to their responsibilities for making Routine Enquiry relating to domestic abuse.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

2.2 The Trust is committed to ensuring that this policy is embedded in operational practice by:

- Ensuring that there is a consistent and effective response to any concerns, allegations, or disclosure of domestic abuse.
- Ensuring staff have the knowledge and understanding of domestic abuse, the Domestic Abuse Pathway and the Safeguarding Adults and Safeguarding Children Procedures and

receive appropriate training in identifying domestic abuse and supporting those who experience it.
- Working in partnership with other organisations including participation in the Multi agency risk assessment conferences. (MARAC)
- Sharing information within legal and professional constraints so that adults at risk and children can be protected.
- Raising awareness of domestic abuse at corporate and local induction.
- Contributing to and learning from the development of policy and practice at a local and national level.
- Participating in learning events following reports and investigations including Serious Case Reviews and Domestic Homicide Reviews.
- Providing resources, within existing constraints to facilitate the implementation of the policy.
- Ensuring full implementation of this policy and the Domestic Abuse Pathway through the triumvirates.

3. Definitions

3.1 Domestic Abuse

3.1.1 The Domestic Abuse Act 2021 defines domestic abuse as:
Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if:

I. A and B are each aged 16 or over and are personally connected to each other, and
II. the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following:
I. physical or sexual abuse.
II. violent or threatening behaviour.
III. controlling or coercive behaviour.
IV. economic abuse
V. psychological, emotional, or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct. Further definitions on the types of abuse can be found on at:
https://www.nhs.uk/live-well/healthy-body/getting-help-for-domestic-violence/
https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/

However, it is important to highlight controlling and coercive behaviour as they are often missed but always evident in retrospective reviews such as Domestic Homicide Reviews. 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. (Section 77 Serious Crimes Act 2015).

3.1.2 It is recognised that the desire to exert power and control underpins the majority of domestic abuse which takes place, and that abuse is usually inflicted to achieve this end.

3.1.3 Trust staff must also consider the actions and needs of service users who may be the alleged perpetrators of domestic abuse, ensuring that this is documented in care records and risk assessment and management plans.

3.1.4 The definition of domestic abuse now uses the term 'personally connected' and staff must consider that victims are not just intimate partners but also family members (See Appendix for further information on the definition of 'personally connected').

The Standing Together briefing on Adult Family Violence (AFV) states "Abusive behaviours most often take place within a wider context of family violence, with the perpetrator offending against other family members and siblings in particular, as well as displaying patterns of threatening behaviour towards intimate partners. Therefore, risk needs to be considered for all family members living in the home." Further information on AFV can be found here https://www.standingtogether.org.uk/blog-3/adult-family-violence-briefing

Domestic abuse may also be perpetrated by adolescents towards their parents. National guidance is available on adolescent to parent violence and abuse. see the Information guide titled Adolescent to parent violence and abuse (APVA).
https://safelives.org.uk/sites/default/files/resources/HO%20Information%20APVA.pdf

It is important to recognise in all forms of domestic abuse but particularly in AFV and APVA that victims may minimise the abuse and behaviours of the perpetrator. This is in part due to complex family relationships, caring responsibilities, and perceived support needs of the perpetrators. Victims are less likely to report to the police and may not see the behaviours as being abusive. All victims of AFV and APVA should be risk assessed using the DASH-RIC on all occasions.

3.1.5 It has been found through multiple Domestic Homicide Reviews that there were missed opportunities to identify carers and offer carers assessment. When working with families we should ensure we identify carers, and refer all eligible persons for carers assessment via Sheffield Carers Centre https://www.sheffieldcarers.org.uk/

Overlaps with other forms of violence and abuse

3.2 Forced Marriage

3.2.1 The Foreign and Commonwealth Office and Home Office definition from the Forced Marriage and Law and the Justice System March 2013

> "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 to force them to do so. 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".

3.2.2 The Anti-social Behaviour, Crime and Policing Act 2014 makes it a criminal offence to force someone to marry, this includes:

- Taking someone overseas to force them to marry (whether or not the forced marriage takes place)

- Marrying someone who lacks the mental capacity to consent to the marriage (whether they're pressured to or not)
- Failing to adhere to a Forced Marriage Protection Order is a criminal offence
- The civil remedy of obtaining a Forced Marriage Protection Order through the family courts will continue to exist alongside the new criminal offence, so victims can choose how they wish to be assisted
- Details of the new law can be found on the Legislation website

3.3 Honour Based Abuse (HBA)

3.3.1 Honour-based' abuse (HBA) is a crime or incident which has or may have been committed to protect or defend the perceived honour of the family and/or community, or when individuals try to break from constraining 'norms' of behaviour that their community is trying to impose. HBA can cover a range of circumstances, not all of which represent domestic abuse, for example if the victim and perpetrator are not personally connected. However, HBA will typically be carried out by a member or members of the family and is likely to involve behaviours specified in the statutory definition of domestic abuse. Honour Based Abuse is not widely recognised as a form of domestic abuse. It is often misunderstood or dismissed in the name of 'culture' or 'tradition.' This can lead to HBA remaining hidden. Abuse and violence against another person is never acceptable.

3.3.2 Honour Killing - An "honour killing" is sometimes carried out when victims' behaviour or actions are perceived to have caused irreversible dishonour to the family or community.

3.3.3 Further information on HBA can be found at https://karmanirvana.org.uk/ who are the UK's leading charity working to end honour-based abuse. Karma Nirvana has a helpline to support victims and professionals who are working with them.

3.4 Female Genital Mutilation (FGM)

3.4.1 FGM is any procedure that is designed to alter or injure a girl's (or woman's) genital organs for non-medical reasons. It is sometimes known as 'female circumcision' or 'female genital cutting'. It is mostly carried out on young girls. A mandatory reporting duty for FGM requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police. FGM is a criminal offence under section 1 of the Female Genital Mutilation Act 2003. Failing to protect a girl from FGM is also criminal offence under section 3A of the 2003 Act. The FGM duty came into force on 31 October 2015. NHS England also require reporting of all current or historical disclosures of FGM carried out on females regardless of age, therefore all SHSC staff members must report any disclosures of FGM to The Corporate Safeguarding Team for data collection purposes.

3.4.2 Please see SHSC Safeguarding Children policy for guidance where a child is at risk.

3.5 Stalking and Harassment

3.5.1 There is no specific definition of harassment, but it is generally acknowledged to cover behaviour that is intended to cause a person alarm or distress or to cause them to fear violence and the abuser knows that their conduct amounts to harassment. Similarly, there is no specific definition of stalking. However, the police and CPS have adopted the following description - a pattern of

unwanted, fixated, and obsessive behaviour which is intrusive. It can include harassment that amounts to stalking or stalking that causes fear of violence or serious alarm or distress to the victim. (Domestic Abuse, Draft Statutory Guidance Framework July 2020).

3.5.2 The impact of stalking and harassment should not be underestimated, and it is an indicator of high-risk domestic abuse. A study of female homicides that occurred because of male violence found that stalking behaviours were present in 94% of cases and in 71% of cases the victim and perpetrator were in, or had previously had, an intimate relationship (Monckton-Smith et al., Exploring the Relationship between Stalking and Homicide, 2017).

Further information and support for victims of stalking can be found at

https://www.solacewomensaid.org/get-help/other-support-services/paladin-national-stalking-advocacy-service

3.6 Potential Indicators of Domestic Abuse

3.6.1 A person's demographics, economic status or physical and mental health are not indicators of domestic abuse, and anyone can be a victim or survivor of abuse irrespective of these factors. It is therefore important that all service users are asked if they are or have ever experienced abuse.

3.6.2 However, there are several indicators that a person may be experiencing abuse and mental illness is a strong factor. According to retrospective study in the BMJ in 2019, the first UK cohort study looking at the associations between domestic abuse and mental illness, reported a "strong association" between exposure to intimate partner violence (IPV) and the incidence of mental illness. The study found that women who have experienced domestic abuse have three times the risk of developing a mental illness, including severe conditions such as schizophrenia and bipolar disorder, compared with those who have not.' https://www.bmj.com/content/365/bmj.l4126

3.6.3 Some indicators of domestic abuse are obvious, for example evidence of physical assault but there are others, less obvious.

- Fear of a partner
- Feeling helpless or emotionless
- Believing that mistreatment is deserved
- Constant humiliation by a partner
- Embarrassment about disclosing ill treatment to close family or friends
- Partner blaming abusive behaviour on the victim
- Partner controlling and micromanaging every aspect of the victim's life
- Stalking, harassment, forced marriage, honour-based abuse, female genital mutilation
- The social media, the internet and new technology are growing areas which perpetrators use to abuse their victims.

3.7 Domestic Abuse Services in Sheffield

3.7.1 The Sheffield Drug and Alcohol/Domestic Abuse Co-ordination Team (DACT) is responsible for commissioning services which support the victims of domestic abuse, and its website has details of a number of available and accessible services in the statutory and non- statutory sectors.

3.7.2 The DACT implements local priorities in accordance with nationally recognised good practice by working with statutory and voluntary sectors partners across Sheffield and service users, to develop services, and ensure that those who need support get it as quickly, easily and as efficiently as possible.

3.7.3 Additionally there is information and guidance about the available domestic abuse services in the city of Sheffield available on the Trust Intranet which can be accessed by following the Safeguarding tab.

3.8 High Risk incidents of domestic abuse - Multi Agency Risk Assessment Conference (MARACs)

3.8.1 The aim of the MARAC is:

- To share information to increase safety, health and wellbeing of victims and their children
- To clarify if the perpetrator poses a significant risk to an individual or to the general community
- To jointly make and implement a risk management plan that provides professional support and reduces the risk of harm to victims and their children
- To reduce repeat victimisation
- To improve agency accountability

3.8.2 The MARAC is designed to enhance, not replace, existing arrangements for public protection, including safeguarding children and adults, and has a specific focus on the safety of the victim and any children. Where abuse is known or suspected then the relevant safeguarding procedures should be utilised along with the MARAC process if appropriate

3.8.3 Anyone can make a referral to the MARAC and the referral and information forms, including the DASH (Domestic Abuse, Stalking, Harassment & „Honour Based Violence") risk assessment tool (Appendix 3) are available on the Safeguarding Team Jarvis pages or on the DACT website at http://sheffielddact.org.uk/domesticabuse/resources/marac-information-and-forms/.

3.8.3 Stalking-DASH-RIC - If stalking is also identified whilst completing the DASH-RIC, please also complete the S- DASH & submit as part of your referral, please see appendix 4.

3.8.4 SHSCFT is represented at the MARAC, by a member of the safeguarding team. Staff can contact the SHSC Safeguarding for advice and support in completing referrals.

3.8.5 The MARAC referral **MUST** be forwarded to shscsafeguarding@shs.nhs.uk. This will enable the correct information to be shared with the MARAC. The referring practitioner must provide additional information and attend the MARAC to share relevant and proportionate information about the alleged perpetrator or alleged victim if they are in receipt of SHSCFT services or have been in 6 months prior to the MARAC.

3.8.6 **DACT Guidance for Disclosures of crimes by victims/ survivors going to MARAC**

Agencies undertaking Domestic Abuse Risk Assessments with victims / survivors are likely to be told about criminal behaviour or criminal incidents e.g., assault, harassment, coercive control, criminal damage, sexual offences such as rape etc.

If the assessment is that the case is high risk and needs to be heard at MARAC, the agency completing the risk assessment and / or presenting the case at MARAC need to consider that the crimes that will be disclosed at MARAC need to be formally reported to South Yorkshire Police. This is because the Police are required to act on all crimes that they become aware of. It would improve the safeguarding of victims and save time for the Police and for MARAC if these crimes are disclosed to SYP before MARAC rather than at the meeting itself.

If a crime has been disclosed and the case is going to MARAC, the referring agency is requested to do the following:

- At the point of disclosure ascertain the victim/ survivors' views as to whether they wish the police to take action in relation to the crimes or not
- Report the crime/s to SYP via the weblink Form (reportingcrime.uk) or 101
- Be clear to SYP that the victim requires:
    - A trauma informed response – this means that action will not be taken other than recording of the crime/s; or
    - An investigation of the crime/s
- Request when reporting to SYP that an incident is **not** created, and the crime is tasked to the "DARA high risk in tray".
- Add your name and contact details and request an update so that you can continue to support the victim if appropriate (e.g., if a trauma informed response is requested but SYP think the issue needs to be investigated because of its seriousness)
- Ensure the DASH risk assessment you have obtained is attached and include details of any safety planning that is in place for the victim.

At MARAC the Police will then already have a record of the incidents / crimes reported and no actions will need to be taken in terms of sharing the DASH etc.

The Corporate Safeguarding Team can support staff with this process.

3.9 Independent Domestic Violence Advocates (IDVA)

3.9.1 The Sheffield wide IDVA Service was created when the Sheffield MARAC was established. The IDVA service is available for any person referred to the MARAC process.

3.9.2 An IDVA meets with the victim and undertakes an assessment of the risks posed to the victim. In cases where the risk assessment has been completed by a referrer from another agency, the IDVAs will contact the victim and offer support.

3.9.3 If a protection plan has been identified by the MARAC, the IDVA"s are responsible for ensuring it is carried out although other agencies might also be involved in a protection plan. i.e. South Yorkshire Police, Education, Mental Health & Physical Health

4. Purpose

4.1 The purpose of this policy is to provide clear guidance supported by education and training which will enable staff to support the victims of domestic abuse.

4.2 In accordance with the Mental Capacity Act 2005, we work from a presumption of mental capacity unless a person's apparent comprehension of a situation gives rise to doubt. (Refer to SHSCFT Mental Capacity Act and Consent to Treatment Policies and Mental Capacity Act, 2005)

4.3 When developing this policy and when developing future policies, the Trust has been and will be mindful of the impact of the policy in relation to disability, race, gender, age, sexual orientation and religion.

4.4 This policy recognises that identifying domestic abuse is a regular part of health and social care assessment and promotes routine enquiry which is timely and should occur at key times, such as: initial assessment, out-patient clinics, follow-up appointments or any other appropriate time in the service user journey. This supports routine risk assessment to ensure that the safety of the service users and staff is maximised.

5. Duties

Executive Director of Nursing - retains the strategic lead for all allegations of abuse made against members of staff. This includes having responsibility for safeguarding across the Trust and Board Level responsibility for the requirements under Section 11 of the Children Act (2004) and the Care Support Statutory Guidance 2014.

Head of Nursing – The Director of Quality holds the corporate lead on behalf of the Executive Director of Nursing, Professions and Operations. This includes having delegated responsibility for safeguarding across the Trust and Board Level responsibility for the requirements under Section 11 of the Children Act (2004) and the Care Support Statutory Guidance 2014.

Head of Safeguarding – will provide advice and guidance within the Trust, liaising with other agencies as necessary and ensure the Trust will continue to contribute to the development of Domestic Abuse services in Sheffield and will be represented at city wide meetings as required.

General Managers, Matrons and Service Managers are responsible for ensuring that all members of staff in their teams have access to this policy either electronically or in a paper version and that they support their staff in identifying and accessing the relevant training.

All staff must be aware of this policy and adhere to the good practice within it.

The directorates are represented at the Trusts Safeguarding Assurance Committee and are responsible for bringing key issues and good practice relating to domestic abuse to this meeting and feeding back to their directorates as part of the Trusts governance arrangements.

6. Children

6.1 The Domestic Abuse Act 2021 has included children as victims of domestic abuse.
Any reference in the Act to a victim of domestic abuse includes a reference to a child who:

I. sees or hears, or experiences the effects of, the abuse, and
II. is related to the victim or perpetrator

A child is related to a person for the purposes of the act if:

I. the person is a parent of, or has parental responsibility for, the child, or
II. the child and the person are relatives.

6.2 Research shows that children experiencing domestic abuse can be negatively affected in every aspect of their functioning including their safety, health, school attendance, school achievement and emotional development. Children suffer both directly and indirectly when living in households where there is domestic abuse. 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others, and 1 in 7 (14.2%) children and young people under the age of 18 will have lived with domestic violence at some point in their childhood. www.womensaid.org.uk

6.3 If children are living in a household and there is known domestic abuse or a disclosure of abuse is made is made by our service users, a referral must be made to the Safeguarding Children's Hub using the agreed multiagency referral form (see guidance on Jarvis pages and the Safeguarding Children Policy). Whilst it is important to be honest and open with service users about the actions we are taking, if you believe a child is at risk of, or likely to be suffering from significant harm, consent from the parent to refer is not required.

6.4 If children are living in a household and there is a known history of domestic abuse or a disclosure of historic abuse, a referral to the health visitor (If the child is under 5 years of age) and/or Safeguarding Children Hub should be considered to ensure the safety of the child.

7. Perpetrators

It has been found through multiple Domestic Homicide Reviews that there were missed opportunities to refer perpetrators to substance and alcohol misuse services. When SHSC are working with perpetrators of domestic abuse and there is a recent history of substance and/or alcohol misuse they must signpost or offer referral to appropriate services.

There are services to support perpetrators who want to address their behaviours.

CRANSTOUN – provides services for adults and young people facing difficulties with alcohol and other drugs, domestic abuse and criminal justice. This is done by education, intervention, and harm reduction. Inspire to Change is a programme designed to empower perpetrators to challenge and change their behaviours. This can be in groups or 1-1 work. Further information on accessing this service can be found here https://cranstoun.org/

8.0 Confidentiality

8.1 Extreme care should be taken to protect the safety of victims of abuse and no information should be disclosed which may breach their safety. For instance, a third party may try and use the whereabouts of children to trace a mother. This would apply even if the enquirer was a professional member of staff, a partner or family member who works in the system.

8.2 However, it must be made clear to service users that there are limits to the extent of confidentiality where the safety of children and adults at risk are concerned. Where children are living in violent households, information may be passed to other agencies in line with child protection procedures and similarly for adults, consistent with safeguarding adults procedures.

8.3 In cases where serious assault has occurred, it is helpful to have the consent of the person to share information with another agency but, as with child protection and work with adults at risk, the welfare of the victim is paramount. Staff can report to the Police without a person's consent. If this is the case, they should tell the person they have done so wherever possible. The presumption is in favour of reporting/disclosing in line with The Data Protection Act (2018) which allows processing for preventing or detecting unlawful acts and UK GDPR has the basis of substantial public interest.

If there is a risk to Children, concerns should be shared immediately with the Childrens Safeguarding Hub. If there is a serious risk to life or safety of the victim or dependents, information may be disclosed without consent and reported to the police.

9. Documentation

9.1 A service users records can form part of future protection for a victim of domestic abuse. The victim may not wish to pursue a prosecution at any particular time but any recording forms part of the history of abuse and may mean that a prosecution can be brought in future.

9.2 Perpetrators of domestic abuse are assiduous in accessing information that will help them perpetuate the abuse so members of staff should try and obtain a safe correspondence detail for victims where information that could put the victim at risk, can be sent.

9.3 Recording incidents of domestic abuse

ALL INCIDENTS OR DISCLOSURES OF DOMESTIC ABUSE MUST BE ENTERED ONTO THE APPROPRIATE SERVICE USER ELECTRONIC PATIENT RECORD (RiO, INSIGHT, SYSTMONE OR PAPER RECORDS)

9.4 All professionals have a duty of care to record incidents of domestic abuse and permission to record the information need not be sought from the victim, but staff should comply with professional guidelines and, as with child protection, should include details of any given explanation and any further observations by the member of staff which contribute to the information base.

9.5 Recording of domestic abuse should include any disclosure, i.e. the description of the incident in the service users own words, a description of any injury/bruising on a body map if possible and the impact of the abuse e.g. their physical and emotional presentation. It is also useful to note who is present, such as a partner, when a history of an injury is being taken. If there were children in the house, were they present at any time of the alleged incident and/or present at the history taking.

9.6 Records can be requested by the police if a criminal investigation is pursued and therefore clear documentation at the time of the disclosure is important.

10. Routine Enquiry

10.1 Service users should be asked routinely about domestic abuse because evidence suggests that one of the consequences of domestic abuse for victims is deterioration in their mental health.

10.2 Disclosure of Domestic Abuse is difficult. Where it is suspected, staff should provide the service user with the Domestic Abuse Helpline number and make sensitive enquiries about abuse in the home. The Corporate Safeguarding Team Jarvis pages has contact details of many local and national domestic abuse services which staff can access to provide to service users in need of this service.

10.3 Staff should be mindful of the impact that domestic abuse can have on the service user's thoughts of self-harm and should consider referral to MARAC as part of their risk management planning, even when the likelihood of significant harm from the alleged perpetrator is not evident. Any instance of domestic abuse between the same victim & perpetrator(s) within 12 months of last referral triggers a repeat referral to MARAC (Safe Lives).

10.4 If it is suspected that a serious assault has occurred, consideration should be given to protection through hospitalisation and/or a report made to the Police.

10.5 Where adults at risk are victims of domestic abuse guidance in the Safeguarding Adults Principles and approach for South Yorkshire and Trust Safeguarding Adults Policy should be followed.

Ensure it is safe to ask:

- Is the environment safe?
- Is it conducive to ask?
- Is it safe to ask?

Consider the appropriateness of the presence of others when asking, even when a service user requests that a person remains.

- Create the opportunity to ask the question
- Use an appropriate professional interpreter (never a family member).

10.7 Ask

Frame the topic first then ask a direct question. Examples:

Framing: "As violence in the home is so common, we now ask all service users about it routinely" Direct Question: "Are you in a relationship with someone who hurts or threatens you?" Did someone cause these injuries to you?" Has someone in your home ever hurt you? Do you feel safe at home?

10.8 Validate

Validate what is happening to the individual and send important messages to the contact:

- "You are not alone"
- "You are not to blame for what is happening to you"
- "You do not deserve to be treated in this way."

10.9 Assess (Use Safelives (CAADA) -DASH Risk Identification Checklist) Assess contacts safety:

- "Is the person here with you?"
- "Where are the children?"
- "Do you have any immediate concerns?"
- "Do you have a place of safety?"

Information taken from:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf

https://safelives.org.uk/sites/default/files/resources/Domestic%20abuse%20guidance%20for%20virtual%20health%20settings-%20C19.pdf

10.10 Refer
Follow the Flow chart at the beginning of this policy and signpost the service user to specialist domestic abuse services.

10.11 Staff should be aware that research indicates that separation from an abusive partner can increase the risk of harm. 75% of domestic homicides occur at or soon after, point of separation (Safelives Domestic Abuse Charity 2015). Unless the service user is at risk of immediate harm, it is safer if leaving can be carefully planned. Advice on safety plans and leaving can found here https://www.womensaid.org.uk/the-survivors-handbook/making-a-safety-plan/#1447926965137-d1ebb2d0-ef20

10.12 Unless the service user requires assistance to communicate e.g., interpreter, they should be **unaccompanied** when asked about domestic abuse. This allows for full disclosure, and it can facilitate information gathering and provision of advice in a safe and confidential space.

10.13 Consideration should be given to any communication needs e.g., English is not the first language, or they use British Sign Language, to support their disclosure and ensure they understand information shared with them. Appropriate professionals should be used, not family or friends.

10.14 The Crime Survey for England and Wales (CSEW) estimated that 2.4 million adults (1.7 million women and 699,000 men) aged 16 years and over experienced domestic abuse in the year ending March 2022. Whilst it is nationally recognised that domestic abuse predominantly affects women and girls (https://www.gov.uk/government/publications/tackling-violence-against-women-and-girls-strategy) it is important that staff remain vigilant to signs of domestic abuse when working with all of our service users and there is a growing recognition that domestic abuse may occur at a similar rate within LGBT relationships as it does within heterosexual relationships. Staff should be mindful of barriers that service users may face due to their culture, religion, gender or sexual orientation. Further guidance and information can be found here adult-safeguarding-and-do-cfe.pdf (local.gov.uk)

11. Information to Service Users

11.1 There is a range of services available for service users who have experienced domestic abuse. Information about these services can be obtained through the Trust Intranet or the DACT website.

11.2 Staff can access additional information from the Department of Health Guidance Responding to domestic abuse - A resource for health professionals (2017)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf

12. Domestic Violence Disclosure Scheme

12.1 Right to Ask

The scheme – also referred to as Clare's Law – aims to prevent men and women from becoming victims of domestic abuse. It gives members of the public a 'right to ask' police if their partner has a violent past if they are concerned their partner may pose a risk to them. It can also be used by third parties who are concerned that the partner of a member of their family or a friend may pose a risk to that individual, this is known as "right to know ". The public referral number is 0114 2196854 or 101. There is information for victims, third parties and perpetrators available on the SHSCFT intranet or on the South Yorkshire Police website http://www.southyorkshire.police.uk/help-and-advice/domestic-abuse/domesticabusedisclosure-scheme

12.2 Right to Know

This enables an agency 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.

12.2.1 If you have concerns and wish to make an application on behalf of a client you must complete the Appendix 5 and submit it to the SHSCFT Safeguarding Team (SHSCSafeguarding@SHSC.NHS.UK). The team will the forward this to Sheffield_PPUReferrals@southyorks.pnn.police.uk Do not call 101 for Right to Know.

If you believe there is an immediate risk of harm please contact 999 or 2222 if you are calling from a SHSC service

13. Service users who do not attend or are not brought to appointments

13.1 People who are known to be experiencing domestic abuse or are at risk of domestic abuse, who do not attend or are unable to attend appointments, should be offered further appointments. The service users GP should be notified of the non-attendance and liaise with any other agencies involved to ascertain the person's safety.

13.2 Consideration must be given to informing other health and social care practitioners and the police of a disengagement with the Trust, as this may indicate an increase in risk of domestic abuse.

14. Discharge and Transfer of Care

Where a service user who is known to suffer domestic abuse is transferred to another service or provider or discharged from our care and treatment, a reference to their experience of domestic abuse must be included in any documentation sent to a GP or healthcare provider. This is to ensure that up to date information around domestic abuse risk is shared with other professionals who may be involved with the service user.

15. Development, Consultation and Approval

The policy has been reviewed by the Interim Head of Safeguarding. Evidence within has been updated to reflect recent local and national best practice and guidance.

Policy has previously been reviewed by:
• Executive Director of Nursing, Professions and Operations
• Trust Lead for Safeguarding

And approved at the Executive Directors Group.

See also Review/New Policy Checklist
Authors have consulted information available from Safe Lives, Women's Aid, adass - Directors of Adult Social Services, Safeguarding Adults Principles and approach for South Yorkshire, Department of Health and the Home Office.

Dates for consultation and review are as per version control.

16. Training and other resource implications

16.1 In order to meet its obligations, the Trust has made training of all staff in adult and child safeguarding mandatory at the required level, to be undertaken a minimum of three-yearly basis (dependent upon role and in line with the NHS Intercollegiate Guidance safeguarding competency pathway as set out by the intercollegiate document guidance):
• Basic training with respect to awareness that abuse can take place and the duty to report.
• Training on recognition of abuse and responsibilities with respect to both Trust and Multi-Agency procedures.

16.2 It is the Trust's expectation that all staff access safeguarding training in accordance with their roles and responsibilities. The training will include sections on the sharing of information and confidentiality in line with national and local protocols. Additional Trust training will also focus on record keeping; promoting the keeping of clear, accessible, comprehensive and contemporaneous records that are in line with national and local protocols.

16.3 The Trust's Electronic Staff Record maintains a record of all children and adult safeguarding training delivered, with reference to appropriate levels achieved.

16.4 The Trust accesses and contributes to the Sheffield Safeguarding Board Partnership training pool, in delivery and receipt of advanced and / or specialist training. Domestic Abuse detailed training session provided via Sheffield DACT (Domestic Abuse Coordination Team) are recommended for registered professionals.

16.5 Further detail in relation to available safeguarding training, levels and competencies can be found in the Safeguarding Training Strategy, which is available on the Trust Intranet.

Additional training is available via Action Housing http://www.actionorg.uk/domestic-abusetrainingbooking-form/

17 Audit, monitoring and review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Annual Audit of staff attending safeguarding supervision using ESR	Audit	Corporate Safeguarding Team	Annual	Safeguarding Assurance Committee	Corporate Safeguarding Team	Quality Assurance Committee
The Corporate Safeguarding Team will produce quarterly reports regarding staff attendance at safeguarding supervision	Report	Head of Safeguarding	Quarterly	Safeguarding Assurance Committee	Corporate Safeguarding Team	Quality Assurance Committee

18 Implementation Plan

Objective	Task	Executive/ Associate Director Responsibility	Timescale and Progress
Dissemination, storage and archiving	Post on Trust intranet (Jarvis)	Director of Corporate Governance	Within 1 week of ratification
Communication of updated policy to all staff	'All SHSCFT staff' email alert and communication in CONNECT	Director of Corporate Governance	Within 1 week of ratification
Cascading of information to all staff	Senior Managers to share with Team/Ward managers to ensure all staff have access to latest version of this policy.	Director of Corporate Governance	Within 1 month of dissemination
Training and development	Ensure up to date information is available at induction for all new staff Training to be provided on Action Learning Sets to ensure Safeguarding Managers and relevant mangers can lead group supervision using this approach.	Exec Director of Nursing	Within 1 month of dissemination

19 Dissemination, Storage and Archiving (Control)

The Trust will ensure that the policy is circulated to all relevant staff using the Trust Jarvis pages and is promoted via the Safeguarding Assurance Committee. Dissemination will take place via:

- Staff Induction
- Safeguarding Training
- Trust Intranet (Jarvis)
- Learning Lessons Hub

20. Links to other policies, standards and legislation (associated documents) *Any policies, procedures, guidelines which link to this policy should be indicated here.*

Domestic Abuse Act 2021
Care Act 2014
The Anti-social Behaviour, Crime and Policing Act 2014
Domestic Abuse - Draft Statutory Guidance Framework (2020)
Modern Slavery Act 2015
Mental Health Act (2007)
Mental Capacity Act 2005
Safeguarding Adults Principles and approach for South Yorkshire (2021)
Working Together to Safeguard Children (2018)
SHSCFT Human Resource Policies
SHSCFT Incident Reporting Policy
SHSCFT Safeguarding Supervision Policy
SHSCFT Safeguarding Children Policy
SHSCFT Safeguarding Adults and Prevent Policy
SHSCFT Raising Concerns at Work (Whistle Blowing) Policy
SHSCFT Access to Care Records Policy
SHSCFT Being Open and Duty of Candour Policy
SHSCFT Confidentiality and Information Sharing Policy

21. References

- Department of Health Guidance, Responding to domestic abuse – a handbook for Health Professionals (2017)
- Ending violence against women and girls in the UK (2013)
- NICE public health guidance 50 - Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (2014) Appendix 2. Training Courses in Domestic Abuse
- Serious Crimes Act 2015
- The Law Commission – Social Media Paper Nov 2018
- Safe Lives Domestic Abuse Charitable Organisation

22. Contact details

Title	***Name***	***Phone***	***Email***
Head of Safeguarding	Hester Litten	271 8484	hester.litten@shsc.nhs.uk
Named Nurse for Safeguarding Children	Angela Whiteley		Angela.whiteley@shsc.nhs.uk
Adult Safeguarding Advisor	Stephenie Barker		Stephenie.barker@shsc.nhs.uk
Executive Director of Nursing	Salli Midgley		Salli.midgley@shsc.nhs.uk
Head of Nursing	Kirsty Dallison-Perry		kirsty.dallisonperry@shsc.nhs.uk
Named Doctor for Safeguarding Children	Helen Crimlisk	275 0719	Helen.crimlisk@shsc.nhs.uk

DASH RISK ASSESSMENT

DOMESTIC ABUSE, STALKING, HARASSMENT & 'HONOUR' BASED ABUSE

AFTER COMPLETING DASH, CIRCLE RISK LEVEL HERE: **High** / **Medium** / **Standard**

Date: **Complete MARAC**

Name of person completing DASH:

Agency:

Referral section if HIGH RISK

PLEASE NOTE - Explicit consent (**or lack of**), for **both** referral to MARAC ***and*** sharing of information must be clearly recorded in **Sections 4 & 4A**. Failure to record this information may result in the form being returned ***and*** a **delay** in it being listed for MARAC

Consent is ***explicitly*** required for **medium/standard** risk cases if you wish to refer to the relevant service

The MARAC Referral should be quality assured by a trained practitioner in your agency (this may be your MARAC rep) and / or your manager before submission[1]. The exception to this may be when it is an urgent referral and it is within 48hrs of the deadline for referrals being accepted.

Name of your MARAC Rep /champion:

Contact number & email address of your MARAC Rep /champion:

SECTION 1 – PERSONAL DETAILS

VICTIM'S DETAILS

NAME :		DATE OF BIRTH:
ADDRESS OF VICTIM: Is it safe to post to this address Y/N If no please provide an alternative	TELEPHONE NO:	ALTERNATIVE CONTACT NO:
	IS IT SAFE TO CALL? Y / N	
	EMAIL ADDRESS:	
	IS IT SAFE TO EMAIL? Y / N	

[1] Failure to complete this ***may*** result in the DASH being returned for further information/quality assurance etc.

Gender (please underline): Male/Female/Trans/ Gender Neutral/Other	**Ethnicity** (please state):	**Disability** (please state - Inc. learning disability):	**Sexual Orientation** (please state):

PERPETRATOR'S DETAILS	
NAME :	DATE OF BIRTH:
ADDRESS OF PERPETRATOR:	RELATIONSHIP TO VICTIM (please state):
For police check purposes - Please state if the perpetrator has ever worked in the military, worked as a lorry driver or if they often travel to other areas or have resided outside of South Yorkshire:	

Gender (please underline): Male/Female/Trans/ Gender Neutral/Other	**Ethnicity** (please state):	**Disability** (please state - Inc. learning disability):	**Sexual Orientation** (please state):

CHILDREN'S DETAILS (IF ANY)
IF YOU RUN OUT OF ROOM PUT DETAILS IN REASONS FOR REFERRAL

NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP TO VICTIM	RELATIONSHIP TO PERPETRATOR	SCHOOL (If known)

GENERAL PRACTIONER (GP) DETAILS FOR THE VICTIM – PLEASE NOTE – THIS IS CONSIDERED MANDATORY INFORMATION
GP Name: **Surgery address:** **Does the victim consent to their GP being notified of the referral made to MARAC? *Yes / No (*delete as appropriate)**

SECTION 2 – DASH RISK ASSESSMENT

THE 4 KEY CRITERIA THAT CONSTITUTE A HIGH RISK REFERRAL:	DEFINITION OF HIGH RISK:
1. **VISIBLE HIGH RISK** 2. **POTENTIAL ESCALATION** 3. **REPEAT INCIDENT *(WITHIN 12 MONTHS OF PREVIOUS HIGH RISK ASSESSMENT)*** 4. **PROFESSIONAL JUDGEMENT**	**A RISK THAT IS LIFE THREATENING AND/OR TRAUMATIC AND FROM WHICH RECOVERY, WHETHER PHYSICAL OR PSYCHOLOGICAL CAN BE EXPECTED TO BE DIFFICULT OR IMPOSSIBLE[2]**

THE CONTEXT AND DETAIL OF WHAT IS HAPPENING IS VERY IMPORTANT.
THE QUESTIONS HIGHLIGHTED IN **BOLD** ARE **HIGH RISK FACTORS**.
TICK THE RELEVANT BOX AND **ADD CONTEXT** **WHEREVER YOU TICK YES**

CURRENT SITUATION	YES	NO
1. Has the current incident resulted in injury? (please state the date this occurred, what the injury was and whether this is the first injury)		
2. **Are you very frightened?** Comment on the level of fear and reasons:		
3. What are you afraid of? Is it further injury or violence? (please give an indication of what you think (name of abuser (s) .....might do and to whom) Kill: Self Children Other (please specify) Further injury & violence: Self Children Other (please specify) Other (please clarify): Self Children Other (please specify)		

[2] **Please note, this means high risk of serious harm and not '*just*' high risk of further domestic abuse**

4. **Do you feel isolated from family / friends** i.e. does (name of abuser (s) .....) try to stop you from seeing friends / family / others?		
5. Are you feeling depressed or having suicidal thoughts? (Give reasons)		
6. **Have you separated or tried to separate from (name of abuser (s) .....) within the past year?**		
7. **Is there conflict over child contact** (please state what)		

8. **Does (.....) constantly text, call, contact, follow, stalk or harass you?** (Please expand to identify what and whether you believe that this done deliberately to intimidate you? Consider the context and behaviour of what is being done)		
CHILDREN / DEPENDENTS (If no children/dependants, please go to the next section)	**YES**	**NO**
9a. **Are you currently pregnant** Due Date:		
9b. **Have you recently been pregnant / had a baby (in the past 18 months)?**		
10. Are there any children, stepchildren that aren't (.....) in the household? Or other dependants in the household (e.g. older relative)?		
11. **Has (.....) ever hurt children / dependants?**		
12. Has (.....) ever threatened to hurt or kill the children / dependants?		

DOMESTIC VIOLENCE & ABUSE HISTORY - ***provide as much information as possible***	**YES**	**NO**
13. **Is the abuse happening more often?** (Give details and frequency)		
14. **Is the abuse getting worse?** (Give details)		
15. **Does (.....) try to control everything you do and/or are they excessively jealous?** (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider honour based violence and stalking and specify the behaviour including the behaviour of extended family)		
16. **Has (.....) ever used weapons or objects to hurt you?**		

17. **Has (.....) ever threatened to kill you or someone else and you believed them?**		
18. **Has (.....) ever attempted to strangle / choke / suffocate / drown you?**		
19. **Does (.....) do or say things of a sexual nature that makes you feel bad or that physically hurt you or someone else?** (specify who/what)		
20. **Is there any other person that has threatened you or that you are afraid of?** (If yes, consider extended family if honour based violence. Please specify who)		
21. Do you know if (.....) has hurt anyone else? (For example children/siblings/elderly relative/stranger. Consider HBV. Please specify who and what: Children? Another family member? Someone from a previous relationship? Other (please specify)		

22. **Has (.....) ever mistreated an animal or the family pet?**		
ABUSER(S)	**YES**	**NO**
23. Are there financial issues? For example, are you dependant on (.....) for money/have they recently lost their job/other financial issues e.g. debt or rent arrears? Give details.		
24. **Has (.....) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life?** (Please specify what) Drugs? Alcohol? Mental Health?		
25. **Has (.....) ever threatened or attempted suicide?**		
26. Has (.....) ever breached bail/an injunction and/or any agreement for when they can see you and /or the children? (please specify) Bail conditions? Non Molestation/Occupation order?		
Child contact arrangements? Forced Marriage Protection Order? Other (please specify)		
27. Do you know if (.....) has ever been in trouble with the police or has criminal history? (If yes, please specify) DVA? Sexual violence? Other Violence? Other?		
OTHER RELEVANT INFORMATION (From victim or officer/worker) WHICH MAY ALTER RISK LEVELS. DESCRIBE: (Consider for example victim's vulnerability – disability, mental health, alcohol/substance misuse and/or the abuser's occupation/interests-does this give unique access to weapons i.e. ex-military, police, pest control)		

RISK LEVEL (please tick): STANDARD: ☐ **MEDIUM:** ☐ **HIGH:** ☐

THE RISK LEVEL MUST BE BASED ON THE REFERRAL CRITERIA AS HIGHLIGHTED IN SECTION 2 ABOVE, *NOT* JUST ON THE NO. OF TICKS

SECTION 3 – MARAC REFERRAL

ALL HIGH RISK CASES MUST BE REFERRED TO MARAC ON REFERRAL FORM BELOW

HIGH RISK = A RISK THAT IS LIFE THREATENING AND/OR TRAUMATIC AND FROM WHICH RECOVERY, WHETHER PHYSICAL OR PSYCHOLOGICAL CAN BE EXPECTED TO BE DIFFICULT OR IMPOSSIBLE[3]

FOR STANDARD AND MEDIUM CASES PLEASE SEE APPENDIX A.

MARAC REFERRAL FORM – FOR HIGH RISK CASES ONLY

Any queries can be directed to the MARAC Coordinator/IDVAS
External: 01302 385852 Internal: 745852
Agencies should continue to follow their own procedures regarding any Child/Adult Safeguarding issues *and* continue to adhere to any agreed Domestic Abuse Policies.

NO. OF RISK ASSESSMENTS COMPLETED BY REFERRER IN LAST 12 MONTHS (with this victim):	
IS THIS REFERRAL A MARAC REPEAT? ***Repeat Definition:*** ☐ **A case which has been previously referred to a MARAC and at some point in the 12 months from the date of the last referral a further incident is identified, which, if reported to the police, would constitute criminal behaviour:** **For example:** **- Violence or threats of violence to the victim (including threats against property); or** **- A pattern of stalking or harassment; or,** **- Rape or sexual abuse; or** **- Any other crime e.g. Criminal Damage**	YES / NO
REASON(S) FOR REFERRAL:	

[3] **Please note, this means high risk of serious harm and not '*just*' high risk of further domestic abuse**

IDENTIFY **IMMINENT RISKS of SERIOUS HARM** TO THE VICTIM/CHILDREN:
IF ANY OTHER AGENCY IS KNOWN TO BE INVOLVED, PLEASE SUPPLY CONTACT DETAILS (NAME, ADDRESS, PHONE NUMBERS ETC)?

SECTION 4 - CONSENT

***When seeking consent, please ensure that it is understood that they are consenting to information being shared (about themselves and any children) with other services where considered appropriate. Also that information may be shared without consent should appropriate thresholds be met.**

IS THIS PERSON AWARE OF THE MARAC REFERRAL?	YES	NO – Give details:
Has consent* been provided by the victim for the case to be referred to MARAC?	YES	NO – Complete Section 4A below
Has consent* been provided by the victim for information to be shared at MARAC?	YES	NO – Complete Section 4A below
Has the parent/carer consented* for information about their child/children to be shared at MARAC	YES	NO – Complete Section 4A below

SECTION 4A – SHARING *WITHOUT* CONSENT[4] - ALLOWED IF THE FOLLOWING CRITERIA ARE MET:

Article 6 of the GDPR covers: *Conditions for processing data*	APPLIES?	**Article 9 of the GDPR covers:** *Conditions for processing* ***Special***	APPLIES?
WITHOUT CONSENT *– **Condition** 4 **Vital Interests** applies, so the processing is necessary to protect someone's life** **** Please ensure local case files are also updated with this information***	YES/NO* ***Please delete as appropriate***	***Category** data **WITHOUT CONSENT**– **Condition** 2 **Processing** is necessary for the purposes of providing for appropriate safeguards for the fundamental rights and interest of the data subject** **** Please ensure local case files are also updated with this information***	YES/NO* ***Please delete as appropriate***

HAS THE VICTIM BEEN REFERRED TO ANY OTHER MARAC? YES / NO IF YES WHERE / WHEN?

[4] **Articles 6 & 9 of GDPR allow for information sharing without consent, one condition from each article must be listed. For more information, please visit the relevant section of the DACT website: www.sheffielddact.org.uk**

SECTION 5 – REFERRER'S DETAILS		
ATTENDING THE MARAC:	**PLEASE NOTE – BY COMPLETING THIS SECTION YOU ARE CONSENTING THAT YOU (OR A REPRESENTATIVE FROM YOUR AGENCY) WILL ATTEND MARAC TO PRESENT THE CASE AND RESPOND TO ANY QUERIES ABOUT RISK ISSUES AND/OR CONSENT**	
REFERRING PERSON'S DETAILS		
NAME & ROLE IN AGENCY:		
ADDRESS:		
TELEPHONE:		FAX:
MOBILE:		
EMAIL:		IS EMAIL ADDRESS SECURE? YES/NO

Please ensure the form is fully completed and checked before sent. The preferred method is sent via email however, the form SHOULD ONLY be sent via a SECURE EMAIL address. Post should only be used if you cannot use E-MAIL or FAX. If you post the form you must use 1st class registered post.

PLEASE SEND THE HIGH RISK MARAC REFERRAL FORM TO THE RELEVANT AREA WHERE THE VICTIM RESIDES (BELOW). ALSO SEND TO THE IDVA SERVICE (FAILURE TO DO THIS WILL RESULT IN A DELAY IN KEY AGENCIES RECEIVING THE INFORMATION, WHICH MAY PREVENT EARLY AND VITAL INTERVENTION BY THESE SERVICES).

SHEFFIELD	DONCASTER
Email: Marac.sheffield@sheffdap.cjsm.net Address: **Sheffield MARAC** **C/O Sheffield IDVAS** **Floor 2, PPU** **South Yorkshire Police** **Snig Hill** **Sheffield** **S3 8LY** **&** **idvas.groupmailbox@sheffdap.cjsm.net** **Tel: (0114) 249 3920 Fax** **0114 2724296**	**Email: marac@doncaster.gcsx.gov.uk** **[One email for MARAC and IDVA service]** **Fax: NOT ACCEPTED Address:** **MARAC Admin** **Domestic Abuse Hub** **Mary Woollett Centre** **Danum Road** **Doncaster** **DN4 5HF**
BARNSLEY	**ROTHERHAM**

Email: Barnsley.marac@barnsley.cjsm.net Tel: 01226 320112 Fax: NOT ACCEPTED Address: Barnsley MARAC C/O IDAS, The Core, County Way, Barnsley S70 4BP & idva.service@barnsley.cjsm.net Tel: 03000 110110	Email: MARAC.referrals@rotherham.gcsx.gov.uk Tel: 01709 254977 Rotherham Metropolitan Borough Council Riverside House Floor 2 Wing A Main Street Rotherham S60 1AE & rotherham.idvas@rotherham.gov.uk.cjsm.net Tel: (01709) 254977

APPENDIX A – for standard and medium risk consent *MUST* be obtained, See SECTIONS 4 & 4A ABOVE. Once this has been confirmed, please send referrals to the area where the victim resides (see below)

SHEFFIELD	DONCASTER
Refer to Sheffield Domestic Abuse Helpline: Tel:0808 808 2241 Email help@sheffielddact.org.uk Secure email helpline@actionorg.uk.cjsm.net (For out of hours housing support call 0800 7311 689)	Refer to Doncaster Domestic Abuse Service: Secure Email: DAC@DONCASTER.GCSX.GOV.UK Helpline : 0800 4701 505
BARNSLEY	**ROTHERHAM**
Refer to IDAS Email: idva.service@barnsley.cjsm.net Tel: 03000 110110 NO FAX Address: IDAS, The Core, County Way, Barnsley S70 4BP	Refer to Rotherham Rise: Tel: 03302020571 Email: Outreach.rwr@rothwr.cjsm.net Address: RWR PO Box 769 ROTHERHAM S60 9JJ

NOTES FOR GUIDANCE

NOTES FOR GUIDANCE:

- Please **type** the form wherever possible, if hand written please use BLOCK capitals.
- Please **complete all parts** of the form in as much detail as possible. **Add relevant information whenever you tick 'yes'** in answer to any of the questions.
- **One** form must be used per victim.
- **For MARAC Referrals** - in the '**reasons for referral'** put as much information in but be brief and concise (for police officers information should be included from all police systems). **NO** extra paperwork is to be sent with the form, just send the referral form only.
- **PLEASE ENSURE YOU HAVE COMPLETED SECTIONS 4 & 4A RE CONSENT – FAILURE TO DO SO MAY RESULT IN A DELAY IN THE CASE BEING DISCUSSED AT MARAC**

WHEN TO SEND THE FORM:

1. MARAC Referral Forms must be with the MARAC administrators **NO LATER** than 8 working days before the date of the MARAC
2. If a case is urgent then you must consider calling an emergency MARAC outside of the normal MARAC framework.

WHEN TO SEND THE FORM: 1. MARAC Referral Forms must be with the MARAC administrators NO LATER than 9 working days before the date of the MARAC. If a case is urgent then you must consider calling an emergency MARAC outside of the normal MARAC framework.

Appendix 4 Risk Identification Checklist for Stalking Cases (VS-DASH 2009)[1]

THE CONTEXT AND DETAIL OF WHAT IS HAPPENING IS VERY IMPORTANT. **TICK THE RELEVANT BOX AND EXPAND WHERE NECESSARY**	Yes	No
1. Are you very frightened?	☐	☐
2. Is there a previous domestic abuse and/or stalking/harassment history? (involving you and/or anyone else that you know)	☐	☐
3. Has (insert name of stalker(s)…..) **ever destroyed or vandalised any of your property?**	—	—
4. Does (name of stalker(s)…..) **turn up at your workplace, home etc. unannounced or uninvited more than three times per week?**	☐	☐
5. Does (……..) **follow you or loiter around your home, workplace etc.?**	☐	☐
6. Has (……..) **made any threats of physical or sexual violence?**	—	—
7. Has (……..) **stalking/harassed any third party since the stalking/harassment began?** (e.g. your friends, family, children, colleagues, partners or neighbours)	☐	☐
8. Has (……..) **acted out violently towards anyone else within the stalking incident?**	—	—
9. Has (……..) **persuaded other people to help him/her?** (wittingly or unwittingly)	☐	☐
10. Is (……..) **known to be abusing drugs and/or alcohol?**	☐	☐
11. Is (……..) **known to have been violent in the past?** (This could be physical or psychological)	☐	☐

the relevant information includes: duration of stalking/harassment, various stalking/harassing behaviours engaged in by stalker, details of threats and violence, your beliefs concerning the stalker"s motives and when it started, weapons owned by stalker, nature of unwanted „gifts"/items left or sent to you and attitude/demeanour of stalker including mental health issues

Risk Factor Definitions – What the Research Tells Us Q1. Are you very frightened?

Research demonstrates that the victim is frequently the best assessor of risk posed to them (Weisz et al. 2000). Stalking often consists of behaviours that, when taken at face value, may appear to be quite ordinary (e.g. walking past the victim"s house, asking the victim to go out on dates). With repetition, however, these behaviours can become menacing, and the victim can feel unsafe and threatened. In all cases (even those where no direct threat has been made or where the victim does not yet have a great deal of evidence) it is important that the extent of the victim"s fear is recorded. Many victims state that it is the uncertainty of what the stalker will do next which causes them the most concern.

Q2. Is there a previous domestic abuse and/or stalking/harassment history? (Involving you and/or anyone else that you know)

One of the best predictors of future behaviour is past behaviour and stalkers are no exception. Research shows that many victims will suffer more than 100 incidents before reporting to the police (Sheridan, 2005). Stalkers may also seem to stop stalking their victim (usually for reasons unclear to anyone but the stalker), only to suddenly resume the harassment at a later date.

Q3. Does (insert name of stalker(s).....) **vandalise or destroy your property?**

A sizeable proportion of stalkers (up to two thirds) will damage their victim"s property (Blaauw et al., 2002) and this includes stalking engaged in by adolescents (McCann, 2000). Property damage may be associated with rage or frustration (perhaps because the offender is unable to attack the victim directly), revenge, a desire to harm something the victim cares about (i.e. destroying her wedding photographs), a wish to undermine her belief in a safe environment (i.e. by cutting brake cables), as a form of threat, or it may be connected with breaking and entering the victim"s property or spying on the victim.

Q4. Does (name of stalker(s)…..) **turn up at your workplace, home etc. unannounced or uninvited more than three times per week?**

Stalking rarely takes place at a distance. Research tells us that nearly all stalking cases will ultimately involve face-to-face contact between victim and stalker (Mullen et al., 2000). Some stalkers may appear or approach their victims regularly (i.e. on the victim"s daily route to work). Others, particularly stalkers with an obvious mental illness, will appear in diverse places at unpredictable times (Sheridan and Boon, 2002). The research informs us that those stalkers who visit the victim"s home, workplace, or other places frequented by the victim more than three times in a week are those who are most likely to attack.

Q5. Does (……..) **follow you or loiter near your home, workplace etc.?**

Most stalkers will be seen by their victims. Such stalkers may be compiling victim-related information or tracking the victim"s habits. Stalkers are a varied group and some will attempt to loiter secretly (even camping out on or in the victim"s property), whilst others will make no attempt at concealment. Whether secretive or overt, whether mentally disordered or not, most stalkers will share a belief that their behaviour is an appropriate response to circumstances. If they do follow you or loiter near you, please keep a log of stalker sightings and behaviour.

Q6. Has (……..) **made threats of physical or sexual violence?**

Stalkers frequently threaten their victim, either directly or indirectly. Examples of indirect threats include sending dead flowers or wreaths or violent images to the victim (often anonymously). Stalkers will often make specific written or verbal threats. Research demonstrates that these should be taken particularly seriously. Stalkers have been known to threaten violence months or even years into the future, and have indeed followed through on their threats.

Q7. Has (……..) **stalked/harassed any third party since the stalking/harassment began?** (e.g. your friends, family, children, colleagues, partners or neighbours of the victim)

There is evidence to suggest that on average, there are 21 people connected to the victim who will be affected (Sheridan 2005). Stalkers will involve third parties for a number of reasons. For example, to upset the victim (i.e.

by harassing the victim"s children), to obtain information on the victim (i.e. by approaching the victim"s friends), to remove perceived obstacles between the stalker and victim (i.e. by harassing the victim"s partner), and/or to punish those perceived as helping or shielding the victim (i.e. work colleagues who state that the victim is not available).

Q8. Has (.....) **acted violently to anyone else during the stalking incident?**
Secondary victims will be identified in a majority of stalking cases, and these can be a valuable source of evidential information. Research suggests that third parties will be physically attacked by the stalker in between 6% and 17% of cases (Mohandie et al., 2006; Mullen, Pathé, Purcell, and Stuart 1999; Sheridan & Davies, 2001). Stalkers who attack those associated with the victim are more likely to also attack the primary victim. Persons perceived as preventing access to the victim or protecting the victim are at particular risk.

Q9. Has (……..) **engaged other people to help him/her?** (wittingly or unwittingly)
The ability of a stalker to pose as other persons and/or to draw information out of third parties should never be under-estimated. Many stalkers will devote hours each day to their stalking campaign, and are capable of stalking their victims for many years (Meloy, 1996). New technologies and social networking sites can facilitate harassment, enabling stalkers to impersonate another on-line; to send or post hostile material, misinformation and false messages (i.e. to Usenet groups); and to trick other internet users into harassing or threatening a victim (i.e. by posting the victim"s personal details on a bulletin board along with a controversial invitation or message) (Sheridan and Grant, 2007).

Q10. Is (……..) **abusing/misusing drugs/alcohol?**
Substance abuse by the stalker has been found to be associated with physical assault on the victim in a significant number of cases (Rosenfeld, 2004). The abuse of various substances by stalkers can contribute both to the basis from which the stalking occurs and to individual violent episodes. Binge drinking or drug taking may directly precede an attack, fuelling obsession, yearning or angry thought patterns, or by lending the stalker the confidence to approach or attack the victim.

Q11. Do you know if (.....) has been violent in the past? (This could be physical or psychological. Intelligence or reported)
One of the best predictors of future behaviour is past behaviour. It may not always be physical violence but could include the psychological impact as well. This might be in terms of coercive control and/or jealous surveillance of the victim (Regan, Kelly, Morris and Dibb 2007) if the stalker(s) feels a real sense of entitlement or ownership of the victim. Generally speaking, stalkers who have been violent before, whether as part of a stalking campaign or in relation to separate offences, are more likely to be violent again.

Appendix 5 SHSC Domestic Violence Disclosure referral

SHSC Application to Domestic Violence Disclosure Scheme

Once you have completed this form please email to SHSCSafeguarding@SHSC.NHS.UK for review by the Safeguarding Team. This should then be sent to Sheffield_PPUReferrals@southyorks.pnn.police.uk

If you believe there is an immediate risk of harm please contact 999

Potential Victim

Name	
Date of Birth	
Insight Number (if known to SHSC)	
Address	
Children"s details including name, DOB or estimated age	

Person posing potential risk

Name	
Date of Birth	
Insight Number (if known to SHSC)	
Address	
Children"s details including name, DOB or estimated age	

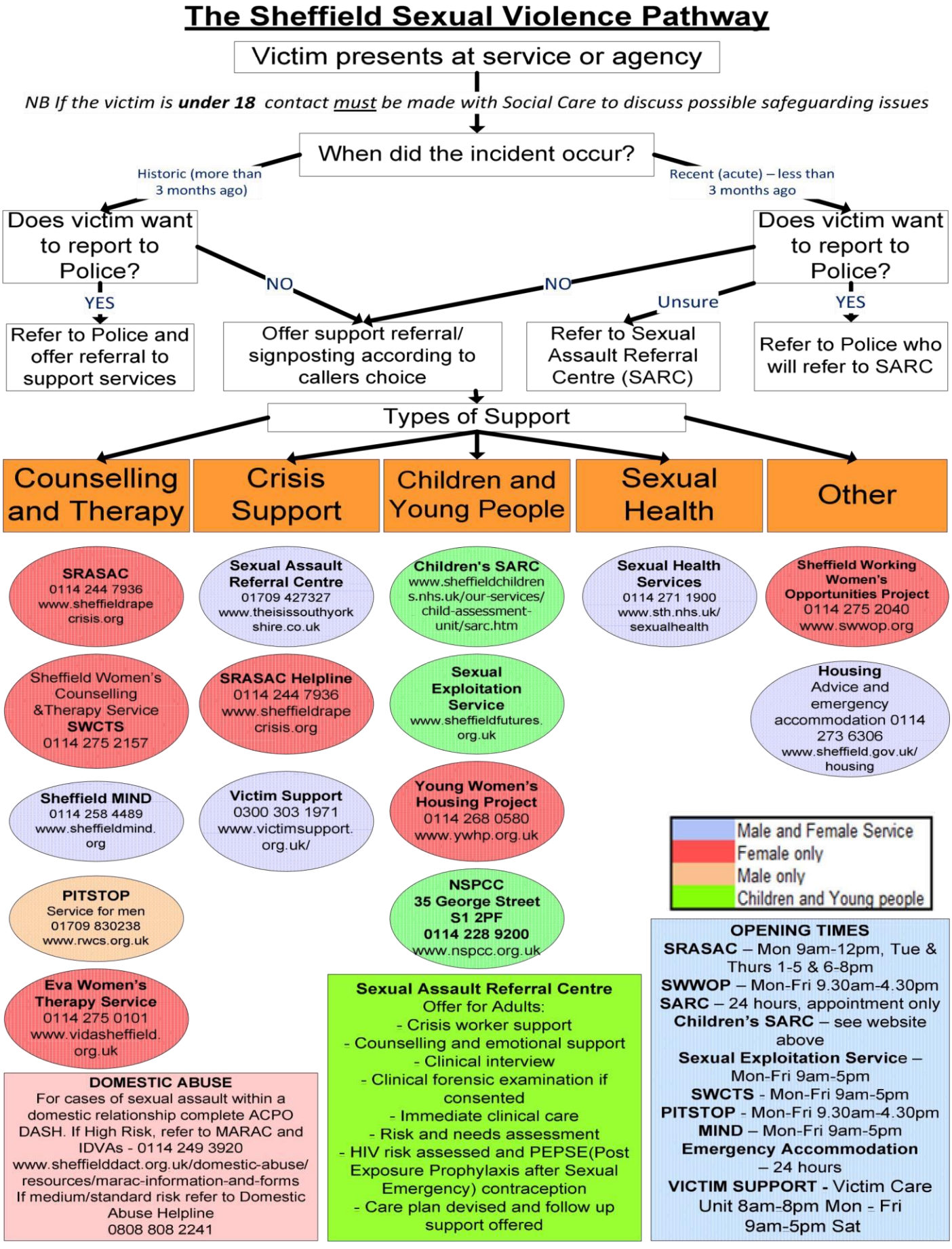
Your details

Name	
Designation	
Team	
Work Address	
Contact Number	
Email Address	
Line Managers Name	

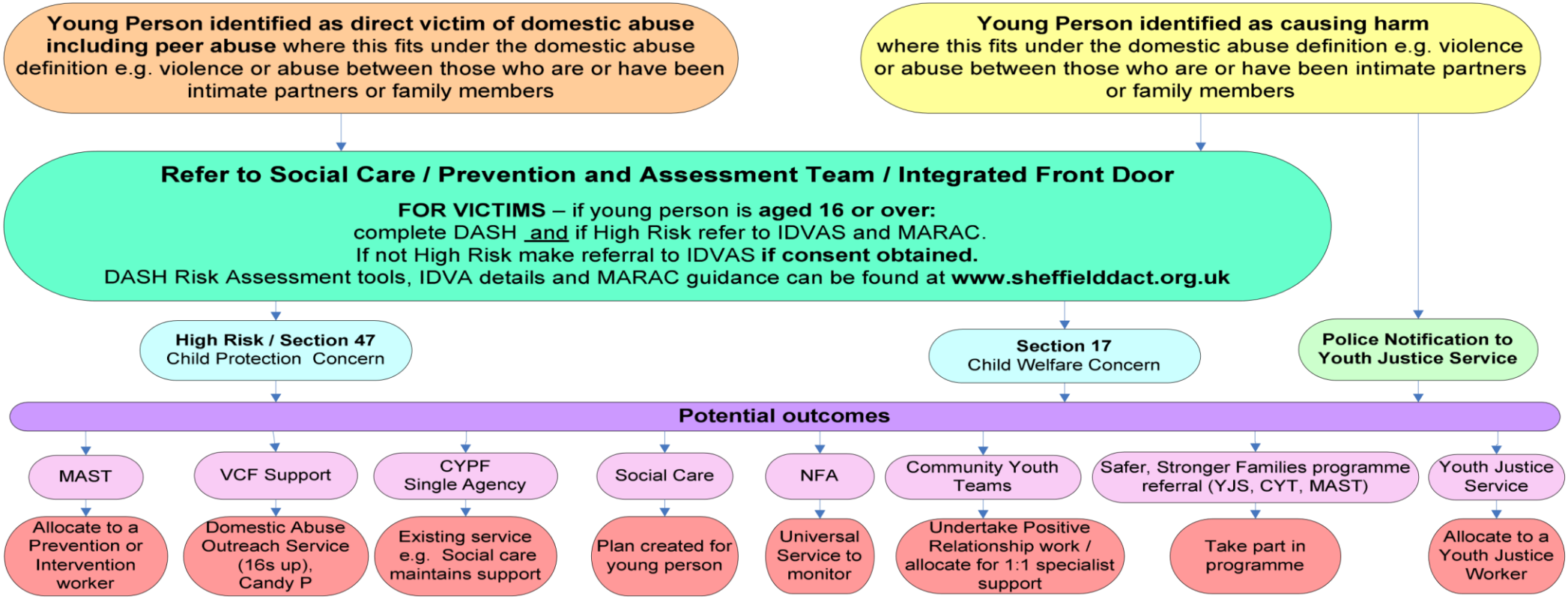
Line Manger Email address	
Client you are involved with	

Please detail the reason for this request

Appendix 6 Sheffield Sexual Violence Pathway



Appendix 7- Sheffield Young People and domestic abuse pathway



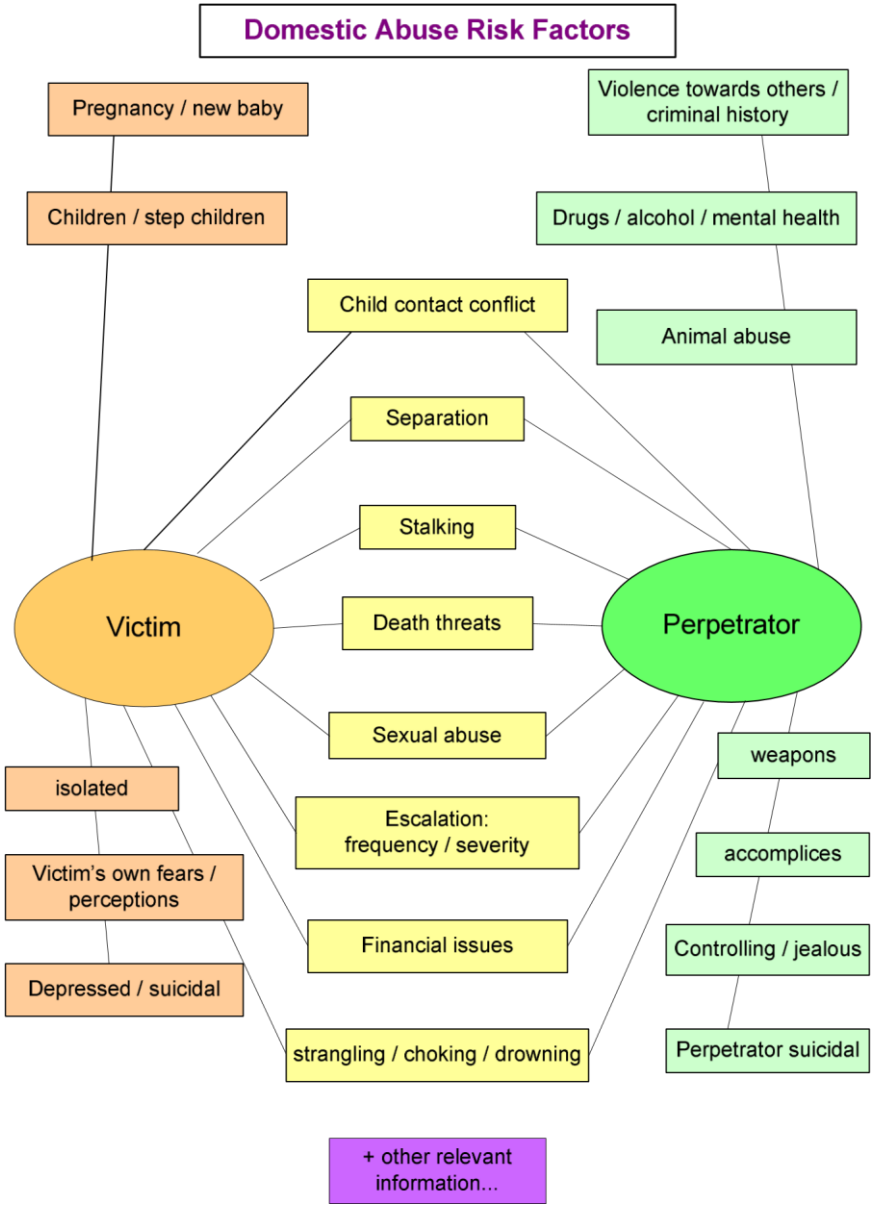
Risk factors - Victim (not exhaustive)

- Very frightened
- Feeling low / depressed / suicidal
- Isolated – from family and friends
- Getting worse / increasing in severity
- Financially dependent on boyfriend / girlfriend
- Separated or tried to separate
- Coerced into sexual activity they are not comfortable with / sexual abuse
- Afraid of further violence
- Injuries
- Escalation / Happening more often
- Pregnant – got a baby
- Afraid of more than one person – multiple perpetrators
- Coercion to use / abuse alcohol / drugs

Risk factors - Young Person causing harm (not exhaustive)

- Using stalking and harassment
- Use of weapons
- Use of strangulation / choking
- Mental health issues
- Threatened to kill themselves
- Breached bail or an order
- Sexting
- History of violence to others
- Jealous and controlling
- Threats to kill
- Mistreated an animal or family pet
- Substance abuse issues
- Criminal history
- Harassment via social media

KEY TO ACRONYMS:
MARAC – Multi Agency Risk Assessment Conference, **DASH** – Domestic Abuse Stalking and Honour Based Violence risk assessment tool, **IDVAS** – Independent Domestic Violence Advocacy Service, **CYPF** – Children Young People and Families department Sheffield City Council, **VCF –** voluntary, community & faith sector, **MAST** – Multi Agency Support Teams, **CYT** – Community Youth Teams, **YJS** – Youth Justice Service, **NFA** – no further action



Domestic Abuse Risk Assessment

Thresholds and definitions

STANDARD RISK:

Current evidence does NOT indicate likelihood of causing serious **harm**

MEDIUM RISK:

There are identifiable indicators of **risk of serious harm**.
Perpetrator has **potential** to cause **serious harm**
But **serious harm is unlikely** unless there is a change in circumstances

HIGH RISK:

There are identifiable indicators of **imminent risk of serious harm.**
Dynamic – an incident could happen at any time and the **impact would be serious**.

SERIOUS HARM:

A risk that is life threatening and / or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.

PROFESSIONAL JUDGEMENT:

Professional: a person who engages in an activity with competence and skill.
Judgement: being able to make an informed decision, based on a balanced viewpoint.

Use professional experience, in conjunction with the evidence based ACPO DASH tool, to assist in identifying and grading risk. Consult line managers, your agency MARAC representative for advice.

Supplementary Section B - Human Rights Act Assessment Form and Flowchart

The Human Rights Act 1998 (HRA) imposes a duty on public authorities to protect, respect and fulfil individuals human rights listed in the European Convention of Human Rights (ECHR)-(Schedule 1 of the HRA).
Some of the rights are absolute, such as Articles Two (the right to life) and Three (freedom from inhuman and degrading treatment. 'Absolute' means there is never any reason that these rights can be limited or interfered with. State bodies (such as the NHS) have a positive obligation to protect individuals from having these rights breached. This means that where there is a known risk (or a risk that ought to be known) to an individual's life or that they may be subjected to inhuman or degrading treatment, state agencies (SHSC) need to take reasonable steps, within the scope of their powers to protect and safeguard these absolute rights. 'Reasonable steps might include:
- Obtaining access to additional information to help you make a decision
- Undertaking risk assessments
-Ensuring all public officials involved in the care of a person at risk have access to all relevant information
Article Eight says 'Everyone has the right to respect for (their) private and family life, (their) home and correspondence'. Article 8 protects bodily and mental autonomy of an individual. Article 8 is a 'qualified right' meaning that there are circumstances in which there is permittable interference, so long as such interference is lawful, justified, and proportionate.

Lawful, means there has to be a lawful framework that gives the authority to restrict their right.

Justified means that there is a compelling justification for the restriction. For example, somebody might be at risk of exploitation or abuse - therefore there might be justification on grounds of protecting their health or article three rights.

Proportionate means there needs to be a reasonable link between the action /interference with a right used and the aim for doing so.

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Hester Litten 12/4/2023	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

The polices considers barriers to disclosure of domestic abuse and accessing services that may be faced by some groups and individuals. Recognition of some of these barriers is covered in Section 10 of the policy and directs the reader to Local Government Association and Adass guide to support practitioners.

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**NO**		
Disability	**NO**		
Gender Reassignment	**NO**		
Pregnancy and Maternity	**NO**		

Race	**NO**		
Religion or Belief	**NO**		
Sex	**NO**		
Sexual Orientation	**NO**		
Marriage or Civil Partnership	**NO**	[redacted]	

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by: Hester Litten
Name /Date: 12/4/2023

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	YES
2.	Is the local Policy Champion member sighted on the development/review of the policy?	NO
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	NA
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	YES
5.	Has the policy been discussed and agreed by the local governance groups?	Yes, has been circulated virtually with Safeguarding Assurance Committee members
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	YES Statutory requirement as per NHS Intercollegiate Guidance
	Template Compliance	
7.	Has the version control/storage section been updated?	YES
8.	Is the policy title clear and unambiguous?	YES
9.	Is the policy in Arial font 12?	YES
10.	Have page numbers been inserted?	YES
11.	Has the policy been quality checked for spelling errors, links, accuracy?	YES
	Policy Content	
12.	Is the purpose of the policy clear?	YES
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	YES – as above
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	YES
15.	Where appropriate, does the policy contain a list of definitions of terms used?	YES
16.	Does the policy include any references to other associated policies and key documents?	YES
17.	Has the EIA Form been completed (Appendix 1)?	YES
	Dissemination, Implementation, Review and Audit Compliance	

18.	Does the dissemination plan identify how the policy will be implemented?	YES
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	YES
20.	Is there a plan to i. review ii. audit compliance with the document?	YES
21.	Is the review date identified, and is it appropriate and justifiable?	YES