# Domestic Abuse Guidelines for Public Health Nursing, Midwifery, and Children’s Nursing Services

**Reference Number:**

NHSCT/12/516

**Target audience:**

Midwifery, Public Health Nursing and Children’s Nursing Service

**Sources of advice in relation to this document:**

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Policy, Standards and Guidelines Committee

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9 May 2012

**NHSCT Mission Statement**

To provide for all the quality of services we would expect for our families and ourselves
Domestic Abuse Guidelines for Public Health Nursing, Midwifery, and Children’s Nursing Services
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Domestic Abuse Operational Protocol and Guidelines for Public Health Nursing, Midwifery, and Children’s Nursing Services

Introduction

Domestic violence and abuse is a pattern of behaviours that is characterised by the exercise of control and the misuse of power by one person (male or female) over another within an intimate or family relationship. It is usually frequent and persistent. While domestic violence and abuse most commonly refers to that perpetrated against a partner, it also includes violence against ex-partners, and violence by a son, daughter, parent or parent-in-law or any other person who has a close or family relationship with the victim.

While the operational protocol and guidelines primarily refer to victims being women or children, nurses should always be alert to the fact that men can also be victims of domestic violence.

Aim and Objectives

The aim is to improve the standard of care given to victims, unborn babies, babies and young children who may be living with domestic violence and abuse

Objectives:

• To develop a consistent approach by Midwives(i.e. hospital and community midwifery staff) , Public Health Nurses (i.e. Health visitors, school nurses and public health staff nurses ) and Children’s Nurses (i.e. acute and community paediatric nursing) when asking about, and responding to disclosures of domestic violence
• To prevent / reduce the escalation of domestic violence by early identification and by appropriate intervention when necessary
• To increase the knowledge, skills and confidence of Midwives, Public Health Nurses and Children’s Nurses in identifying and managing issues relating to domestic violence and supporting and assisting women to make informed choices about their safety and lifestyle
• To contribute to safeguarding children

Principles

The protocol and guidelines are based on the following principles:

• Routine & Selective enquiry
• Consistency of response
• Equality
• Confidentiality
• Documentation
**Target Audience**

Midwifery, Public Health Nursing and Children’s Nursing Service.

**Responsibilities**

**Assistant Director**

The Assistant Director for Children’s and Related Services has overall responsibility for monitoring the implementation and operation of this policy.

**Lead Nurse**

The Lead Nurse in midwifery, public health nursing and children’s nursing service has operational responsibility for monitoring the implementation and operation of this policy.

**Midwifery, Public Health Nursing & Children’s Nursing Staff**

Staff have responsibility to familiarise themselves and follow the Domestic abuse operational protocol and guideline

**Legislative compliance/Other relevant policies and procedures**

This should be read in conjunction with Area Child Protection Committees’ Regional Policy and Procedures (ACPC 2005), Northern Health and Social Care Trust (NHSCT) Safeguarding Children Operational Guidance for Nursing and Midwifery and NHSCT Domestic Abuse Policy.

**Equality, Human Rights and DDA**

The policy is purely clinical/technical in nature and will have no bearing in terms of its likely impact on equality of opportunity or good relations for people within the equality and good relations categories.

**Alternative formats**

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

**Sources of Advice in relation to this document**

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.
A Definition of Domestic Violence

“Threatening behaviour, violence or abuse (psychological, physical, verbal, financial or emotional) inflicted on one person by another where they are or have been intimate family members, irrespectively of gender or sexual orientation” (DHSSPS 2005). It is important to note that domestic violence has more than one victim as it can impact adversely upon children and the wider family unit.

Domestic Violence and Its Impact

Domestic Violence currently accounts for about one fifth of all recorded crime in Northern Ireland. No other type of crime has as high a rate of repeat victimisation as domestic violence.

Impact on Women

- Approximately one out of every five women will experience domestic violence at some point in her life (NI Crime Survey, 2003/04)
- Domestic violence does not only result in short term injury and health impairment but can also result in long term negative health consequences.
- Chronic health problems such as gastro-intestinal symptoms, cardiac symptoms, chronic pain, fainting and seizures have all been identified as resulting from the direct trauma, and associated fear and stress, of domestic violence.
- It is estimated that 40-45% of abused women suffer a combination of physical and sexual abuse.
- Abused women are three times more likely than other women to suffer from things such as sexually transmitted diseases, vaginal bleeding, fibroids and chronic pelvic pain.
- Mental health problems, particularly depression and post-traumatic stress disorder, are associated with domestic violence; evidence indicates that depression can be both triggered and exacerbated by a violent relationship.
- Mortality associated with domestic violence arises from suicide as well as from murder.

Impact on children

- It is estimated that upwards of 11,000 children in Northern Ireland are living with domestic violence (DHSSPS, 2005)
- Domestic violence can lead to miscarriage/premature labour and stillbirth
- Exposure to domestic violence affects the cognitive, emotional, physical and social development of children.
- Domestic violence is more prevalent in homes with younger children than with older children (UNICEF, 2006)
- The impact of domestic violence varies according to the child’s stage of development. (Appendix 1)
• Infants may suffer from fretfulness, sleeplessness, failure to thrive or brain damage leading to disability
• Young children may suffer from bed-wetting, aggression, attention-seeking behaviour, anxiety, poor concentration or poor social and play skills
• Older children may perform poorly at school, have poor school attendance or over achieve, self harm, have eating disorders, be involved in bullying, as a bully or victim
• Teenagers may run away from home, abuse drugs or alcohol, fall pregnant (to escape from home) or may join in the abuse (DOH 2005).
• Domestic violence is an important indicator that a child may be at risk of suffering significant harm.

Indicators of Domestic Violence

There is no typical profile of a person who is experiencing domestic violence; it is for this reason that routine enquiry is being introduced. However, there are some signs and symptoms that may indicate that domestic violence is occurring.
• Contusions, abrasions, lacerations, burns, bites, fractures and sprains especially those that are unattended and of different ages, also multiple sites of injury, repeated or chronic injuries, and those that are inconsistent with the given explanation as to how they occurred.
• Stress may result in physical symptoms such as sleep and appetite disorders, fatigue, chronic headaches, chest pain, palpitations and dizziness, abdominal and gastrointestinal complaints, and deliberate self-harm.
• Gynaecological and obstetric problems may be indicators of abuse; such things as repeated miscarriages or termination, stillbirths, pre-term labour or low birth weight babies, substance abuse, unplanned or unwanted pregnancy, frequent urinary tract infections, pelvic pain.
• Emotional symptoms may also be apparent such as depression, panic attacks, self-harm or suicide attempts, substance abuse, frequent vague complaints and frequent use of minor tranquillisers or pain killers
• Victims may appear frightened, ashamed or embarrassed and be reluctant to speak in front of, or disagree with, their partners; partners may answer questions for them and seem possessive and controlling or overprotective.
• Partner is always present

Routine Enquiry by Midwives/Health Visitors

• Departmental Policy (DHSSPS 2006) dictated that from March 2007 routine enquiry for domestic violence is carried out on all pregnant women (regardless of race ethnicity and ability) and must include women who have experienced miscarriage or stillbirth
• Midwives and Health Visitors use the process of routine enquiry in the pre and post natal period therefore communication between midwives and health visitors is essential and is a two way process
Routine enquiry should never be treated as a one off activity
Enquiry at specified intervals increases the likelihood of a woman feeling safe enough to talk about her abuse. For example, women who develop a relationship with health professionals during a pregnancy might be more open to choosing to disclose abuse once the relationship is well established
Routine enquiry and providing information involves asking all women if they are experiencing domestic abuse whether or not they show signs of it
Asking all women helps avoid stigma and inappropriate judgements
Routine enquiry and the provision of information is not a cure – it contributes to helping women access support if they choose

Midwives

All women must be asked about domestic abuse at least twice during their contact with midwifery service.

The appropriate times are;
- At booking (or subsequent antenatal review visit)
- During postnatal period (if an inpatient, on discharge from hospital)
and
- at any other time on cause or suspicion (Selective Enquiry)

The midwife must complete the Routine Enquiry field on the NIMATs (Northern Ireland Maternity System) and complete MHHR (Maternity Hand Held Record) documentation. If it is not appropriate at these times, document in departmental confidential documentation file.

Health Visitors

Health visitors must complete routine enquiry twice within family health assessment. The appropriate times are at the first contact – i.e. antenatal review /new birth review (including after stillbirth) and at the 14 - 16 week review

Other appropriate times are:
- Transfer into area
- Following miscarriage (if known to health visitor)
- At any time on cause or suspicion (selective enquiry)

If routine enquiry it is not completed at recommended times – staff must document in family health assessment why routine enquiry was not made and endeavour to complete at next contact.
Asking the Question (Midwives/ Health Visitors)

- Provide/Arrange a safe supportive environment
- Never raise the question unless the woman is alone
- The only exception to this is when a professional interpreter is present (Children should not be used as interpreters)
- Ensure privacy
- Think of your conversation as the start of a process not a “one off” event.
- Card with question printed may be used where there are concerns regarding privacy in the home
- Offer every woman information on the Domestic Violence 24 Hour Helpline (0800 917 1414) and Support Services, regardless of the reply
- Accept no as an answer and continue to be supportive

Possible Indirect Questions

- Is everything all right at home?
- Is your partner supportive?
- Are you being looked after properly?
- Is your partner taking care of you?
- Do you ever feel frightened of your partner or other people at home?

Possible Direct Question

I am sorry if someone has already asked you about this and I don’t wish to cause you any offence but we know domestic violence is common and that many people experience violence at home at some time during their life. Can I ask if this has ever happened to you?

Selective Enquiry by Midwives/ Public Health Nurses & Children’s Nurses

- At any time any nurse may see something that indicates a person might be experiencing domestic violence. If this occurs – ask the question
- Never ask when somebody else is present
- The only exception is when professional interpreter is present
- Don’t be afraid to ask direct questions such as:
  - Has your partner ever hit you?
  - Are you afraid of your partner?
  - Do you feel safe at home?
  - Does your partner control you?
  - Is your partner verbally abusive?
- Be honest if you think an injury is inconsistent with the explanation and explain that you are concerned
- Give information on Support Services and Helpline Number regardless of reply
- Accept “no” as an answer and continue to be supportive
Disclosure

The fundamental approach to practice must be that of working with a victim at their own pace and providing support in a non-judgemental way.

It is important that the Midwife/ Public Health Nurse /Children’s Nurse

- Listens carefully and responds constructively without being judgemental
- Validate that what is disclosed is wrong and not their fault
- The Midwife/ Public Health Nurse / Children’s Nurse must offer choices and support to the victim (see under Response)
- Think of a multi-agency approach
- Explain the boundaries and limits of confidentiality (see under Confidentiality and Consent)

Confidentiality

While extreme care should be taken to protect the safety of victims of violence and information should not be disclosed to a third party that might breach their safety, it needs to be made clear that there are limits to the extent of confidentiality and that in cases where children are living in a violent household information may be passed to other agencies in line with child protection procedures and associated information sharing guidance (DHSSPSNI 2009) and similarly for adults in line with vulnerable adult guidelines.

Consent

- Midwives /Public Health Nurses /Children’s Nurses should discuss whether information might be shared with other health colleagues or agencies that can provide additional support or information
- In cases of a serious assault consent should be sought to share information with police and social services but as with child protection and vulnerable adults guidelines the welfare of the child/victim is paramount, therefore, following a risk assessment, if there is a serious risk to life or safety then information may need to be disclosed with or without consent

Response

- Victims who disclose domestic violence should be given appropriate support and information
- Consider the need for medical examination
- Victims should be advised that domestic violence is a criminal offence
- It is important that the information that is given is up to date and accurate
- Advise of local/ national support agencies (Appendix 2)

Domestic Violence 24 Hour Helpline Number 0800 917 1414
• Local Woman’s Aid
• Cithrah
• Police Service Northern Ireland (PSNI) / Domestic Violence Officer (DVO)
• Multi-agency Risk Assessment Conference (MARAC) (Appendix 3)
• Northern Ireland Housing Executive (NIHE)
• Social Services
• Legal Services
• Victim Support
• Men’s Organisations
• Hospitals, local health centres and clinics must display information about the availability of resources to assist victims of domestic violence
• Information about local resources is made available within the Personal Child Health Record (PCHR)
• Carry out a Risk Assessment (see under Risk Assessment)
• Provide support and information to help victim make a decision on what to do next
• Encourage her to have a safety plan (DOH, 2005) (Appendix 4)
• Women experiencing domestic abuse can use these safety plans, but the questions are meant as a guide or prompt rather than as forms to be filled in. Remember that it might not be safe for women to fill in safety plans and take them away.

Never advise a woman to leave her partner. Women are at high risk of injury or murder when they leave a violent partner so leaving immediately might not be the best option

Risk Assessment

• The majority of children living with domestic violence meet the criteria of “Children in Need” (DHSSPS 2003)
• Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment should be commenced
• Immediate referral to Social services’ gateway team (by telephone) may be required if professional judgement is the child is in need of protection. This should be followed up with written UNOCINI within 24 hours (ACPC 2005)
• Social services’ gateway teams need to log incidents of domestic violence and be alert to future reported incidents
• As well as UNOCINI assessment, midwife/health visitor/children’s nurse may consider Barnardos’ Domestic Violence Risk Identification Matrix www.barnardos.org.uk (further guidance Appendix 5)
• Discuss with line manager / Safeguarding Children Nurse Specialist (SCNS)
• When assessing risk to the adult victim refer to the CAADA-DASH risk identification checklist. www.caada.org.uk/libraryresources.html#2
• Refer to MARAC if assessed as high risk
Reporting/Referring

- The midwife/public health nurse/children’s nurse must advise their line manager/SCNS if there are specific concerns for the child or woman at any point of the process.
- The situation may require urgent referral to Social Services’ Gateway team by telephone.
- Liaise with any other relevant professional e.g. health visitor, midwife, community nurse, social worker, GP.
- At each point of the process consider the child as ‘a child in need’ or ‘a child in need of protection’ under the Children (NI) Order 1995 (DHSS 1995) and consider completion of UNOCINI for referral to social services and other relevant agencies.
- At each point of the process consider the victim as a vulnerable adult.
- At any point of the process the midwife/public health nurse/children’s nurse must advise their line manager/SCNS of concerns for her or his own safety.

Record Keeping

Midwives

- Midwives must document response to Routine Enquiry on NIMATs field in outpatients menu or postnatal menu and categorise disclosure:
  01 No disclosure
  02 Disclosure – Family receiving services
  03 Historical Disclosure
  04 Disclosure
- It is the responsibility of the midwife who asked the Routine Enquiry question to complete the MHHR tick boxes on the antenatal visits section or postnatal discharge checklist, as appropriate;
  - To indicate to staff the question has been asked, put a tick in the first box.
  - To highlight to staff there has been no issue identified, put a tick in the second box.
  - To indicate to staff the question has been asked, put a tick in the first box.
  - To highlight to staff there has been an issue identified, put a cross in the second box.
- If an UNOCINI form has been completed at any time during the pregnancy, it is important that the midwife who completes the form or first becomes aware a form has been completed, indicates this in the MHHR by placing a tick in the box next to ‘UNOCINI Form Completed’ on the antenatal visit section.
- All information is recorded within departmental confidential documentation file.
Health Visitors

- Health visitors must document response to routine enquiry within the family health assessment in section 4: Maternal Health - “date of Routine Enquiry and tick disclosure Yes □ No □.”
- Health Visitors must record all incidents and source of information within the family health assessment, family health plan and in chronology of significant events.

Midwives/Public Health Nurses /Children’s Nurses

- If a disclosure of domestic violence has been made either on routine or selective enquiry, the midwife/public health nurse/children’s nurse must discuss with the woman the importance of documenting the abuse, including what information needs to be documented, and seek her consent to do so.
- Records can provide concrete evidence of abuse and may prove crucial to the outcome of any legal case. Good recording will mean that civil or criminal proceedings may be brought more easily in the future.
- Information must not be documented in any handheld records or in records, which the perpetrator has access to.

Record

- Date, time, place of contact
- Document all injuries, bruising, trauma in as much detail as possible, and record if an injury and the victim’s explanation for it are consistent
- If possible draw a body map to show the injury
- Keep records as detailed as possible e.g. “client states she was punched twice in the stomach by husband rather than “patient assaulted”
- Use the client’s own words, record a brief statement from the victim regarding how the injuries occurred and who caused the injuries and if any witnesses were present
- Record the name of the perpetrator if given and his relationship to the victim
- Give names of witnesses, including children
- Record a brief statement regarding the history of violence e.g. “this is the 4th incident of physical violence involving episodes of slapping/ bruising by husband John” record if there is any escalation in the episodes
- Use non-judgemental terms in describing the statements as to cause of the injuries. Use phrases like “the woman said” or “Mrs Smith states….” Avoid statements like “the woman claims” or “patient alleges”
- Apply professional judgement to the observations and record your actions
- Record risk assessment and action taken (recommended in cases of actual harm to the client/child) including liaison with other agencies and its outcome.
• Documentation must also include the agreed action plan to provide clarity around any decisions and subsequent contact with the client/family. If a woman is unable to follow through actions discussed, this should be documented by the midwife/public health nurse/children’s nurse and further support offered.
• Consider and record the names of all adult members in the household. This is particularly important where there are a number of co-habitees.

Legal Position

A Solicitor can offer legal services in the event of domestic violence occurring. The legislation is the Family Homes & Domestic Violence (Northern Ireland) Order 1998 and The Law Reform (Miscellaneous Provisions) (NI) Order 2005

The Family Homes and Domestic Violence (Northern Ireland) Order 1998 tackles two separate but inter-related problems; providing protection for one family member against violence or molestation by another and regulating occupation of the family home where a relationship has broken down. (DHSSPS 2005)

The main powers of the order involve
• Non-Molestation Orders
• Occupation Orders

A Non-Molestation order prohibits a person from molesting, annoying or interfering with the person who makes the application or a child on whose benefit the application has been made

The legislation covers married, non-married and other family members such as parents or sons or daughters

It also includes same sex couples and certain people making application on behalf of children

Occupation orders and exclusion orders determine who is allowed to occupy the home and can direct another person to leave. They may prove helpful in excluding abusers from a household (DHSSPS 2005)
References

- ACPC 2005  Area Child Protection Committees’ Regional Policy and Procedures
- All Wales Pathway, Antenatal Routine Enquiry for Domestic Abuse
- Barnish M, 2004 Domestic Violence, A Literature Review, HM Inspectorate of Probation
- Bell M, McGovern J, A Risk Assessment Model for Domestic Violence, Barnardo’s NI
- DHSSPS 2003 Co-Operating to Safeguard Children, DHSSPS
- DHSSPS 2006, Circular ref HSS NMG 01/06
- DOH 2005, Responding to Domestic Abuse, A Handbook for Health Professionals, DOH
- DHSSPSNI 2009 Agreed Standards and Criteria for Information Sharing for Agencies working with Families and Children in NI (Consultation Document) DHSSPSNI
- DHSSPS 2009, Regional Maternity Hand Held Record User Guidelines Manual, DHSSPSNI
- NI Crime Survey 2003/04
- NHSCT, Safeguarding Children, Operational Guidance for Nursing and Midwifery
- NMC 2009  Record Keeping: Guidance for Nurses and Midwives
- UNICEF 2006 Behind Closed Doors, The Impact of Domestic Violence on Children
Appendix 1

The impact of domestic violence on child development

This document considers the impact of domestic violence on children, it is not meant to be overly prescriptive. It is based on the analysis of: H. Clever et al (1999) Children’s Needs-Parenting Capacity the Impact of Parental Mental Illness, problem Alcohol and Drug Use and Domestic violence on Children’s development.¹

The impact of domestic violence on child development will depend on a variety of factors such as gender and cultural background of the child, the nature and extent of the abuse witnessed, the amount of support received, their age and developmental stage.

Stage 1: The child from 0-2 years

<table>
<thead>
<tr>
<th>Areas of Development</th>
<th>Impacts of Domestic Violence</th>
<th>Warning signs</th>
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</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td>Foetal damage could result from physical violence against the mother - foetal fracture, brain injury, organ damage.</td>
<td>a) Depressed, withdrawn mother; b) Signs of current or previous physical abuse of parent and baby; c) The baby is jumpy, nervous and crying a lot; d) The baby has sleep &amp; eating disturbances; e) The baby is not responsive or cuddly.</td>
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<tr>
<td></td>
<td>• Miscarriage</td>
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<td>• Premature birth</td>
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<td>• Low birth weight and still birth.</td>
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<td>Young children may suffer physical assault as part of the violence against a parent or be physically harmed or hit and be at risk of:</td>
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<td>• Absorbing a dangerous/violent atmosphere</td>
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<td>• Rough handling</td>
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<td>• Disturbed sleep</td>
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<td>• Witnessing/hearing domestic violence</td>
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<td></td>
<td>• Being shouted at</td>
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<td></td>
<td>• Having toys broken</td>
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<td><strong>Intellectual Development</strong></td>
<td>Depressed parents have been shown to:</td>
<td>Poor language skills in the infant.</td>
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<td>• Respond less frequently to their baby’s cues</td>
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<td></td>
<td>• Or modify their behaviour according to that of their infant.</td>
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<td>Some research suggests this can lead to delays in an infant’s expressive language and ability to concentrate on and complete simple tasks.</td>
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<td><strong>Identity</strong></td>
<td>The infant may develop identity problems if parents or carers call the child by different names or if they are highly critical of the child and show little warmth.</td>
<td>As above</td>
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</table>

¹ This document has been adapted from the report: CAFCASS (2005) Putting children and young people first: Domestic violence policy and standards.
A parent whose depression is caused or compounded by living in an abusive environment may emotionally detach from the child.

A baby who is withdrawn and difficult to engage in play or communication.

**Stage 2: The child from 3-4 years**

<table>
<thead>
<tr>
<th>Areas of Development</th>
<th>Impacts of Domestic Violence</th>
<th>Warning Signs</th>
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| **Health**           | • A parent suffering from domestic violence may be limited in their capacity to protect their child from physical danger and provide a child with feelings of safety.  
• This may be demonstrated by a poor physical condition of the child:  
  o The child may appear unfed or unwashed and;  
  o Have marked development problems especially in language. | a) Poor physical neglected condition;  
b) Signs of current or previous physical abuse of the child;  
c) Poor language skills;  
d) Sleep problems;  
e) Delayed toileting;  
f) Frequent visits to the GP and hospital. |
| **Intellectual Development** | • The child may show a lack of interest in their environment and poor intellectual development.  
• Children living in a violent environment may be too frightened to show inquisitive behaviour.  
• Their attendance at pre-school facilities may be disrupted because an abused parent may wish to conceal the evidence of domestic violence. | a) Little awareness and/or understanding of their environment;  
b) Problems relating to other children. |
| **Identity**         | Children of this age often blame themselves for their parents’ problems.  
Reports from abused parents suggest that infants who witness domestic violence try to protect their parent. Children may be harmed by:  
• Trying to intervene  
• Taking sides | As above |
| **Family & Social Relations** | The child may experience:  
• Inconsistent parenting  
• Emotional unavailability  
• Exposure to inappropriate carers and separation. | a) Overly aggressive and bullying behaviour of peers/siblings;  
b) Controlling behaviour over siblings; |
This can cause children to become fearful or unnaturally vigilant believing they are in continual danger.

Children may develop inappropriate behaviour and insecure attachments through apathy and disinterest in their environment. Alternatively they may exhibit controlling behaviour, which can be accompanied by inner turmoil.

Infants may cope with disturbing parental behaviour by appearing not to respond. These children may appear to be coping with the violence, but in reality they are likely to be trying to prevent further frightening responses from the parent.

<table>
<thead>
<tr>
<th>Emotional &amp; Behavioural Development</th>
</tr>
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<tbody>
<tr>
<td>Research suggests that when children experience frightening parental behaviour they can demonstrate symptoms similar to post traumatic stress disorder. This includes:</td>
</tr>
<tr>
<td>• Bed-wetting,</td>
</tr>
<tr>
<td>• Sleep disturbance- nightmares</td>
</tr>
<tr>
<td>• Rocking</td>
</tr>
<tr>
<td>Children who have witnessed and experienced domestic violence demonstrate significantly more behavioural problems than those who have only witnessed the abuse. Pre-school children can be at greater risk of emotional disturbance than older more articulate children because they are less able to communicate this verbally</td>
</tr>
<tr>
<td>Behaving in a nervous or jumpy way.</td>
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<table>
<thead>
<tr>
<th>Stage 3: The child from 5-9 years</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Areas of Development</th>
<th>Impacts of Domestic Violence</th>
<th>Warning Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Children may be harmed in the course of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Defending one parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physically intervening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Calling police or other help</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Being asked to collude with the secrecy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Living with the fear of serious injury or desertion by one or both parents</td>
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</tr>
<tr>
<td></td>
<td>There is an increased risk of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Frequent visits to the GP and hospital;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Bed wetting;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Depressed, withdrawn behaviour;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) High level of school absenteeism.</td>
<td></td>
</tr>
</tbody>
</table>
- Extreme anxiety, fear. This brings an increased risk of medical problems including:
  - Injuries
  - Convulsive disorders
  - Increased frequency of hospitalisation.
Children can also show other health related issues which may include:
  - Stomach pains, headaches, asthma, allergies
  - Disturbed sleep patterns.
Children’s ill health may go unrecognised because of:
  - School absenteeism
  - As a result of parenting problems
  - May mean school medicals are missed.

<table>
<thead>
<tr>
<th>Education</th>
<th>Some research suggests that children of this age, from a violent home can display a gender split in their cognitive development.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Boys display aggression and anxiety,</td>
</tr>
<tr>
<td></td>
<td>• Girls are more likely to underachieve in school.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identity</th>
<th>Children living in a violent environment are at risk of developing low self-esteem and a belief that they are unable to control events in their environment.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>As above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family &amp; Social Relationships</th>
<th>Children may also believe that what they do triggers the violence between their parents. Children can feel helpless and guilty in these circumstances. Inconsistent parental behaviour may cause anxiety and faulty attachments. When separation from an attachment figure is unavoidable children of this age may demonstrate lower levels of distress than younger children because of their increased understanding of time.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The appearance of poor attachment to either parent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Presentation</th>
<th>When parent’s problems lead them to behave in unpredictable or embarrassing ways children want to keep it a secret. Children can feel ashamed or embarrassed about the behaviour amongst anyone outside the family.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clear avoidance of discussing family life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional &amp; Behavioural Development</th>
<th>Gender may influence the child’s reaction to violence. Boys are more likely to act out their distress:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Anti-social and aggressive behaviour such as lying, stealing, attention seeking and attacks on</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extreme fluctuation of moods and emotions during conversation</td>
</tr>
</tbody>
</table>
peers. Girls tend to respond by:
- Internalising their worries, showing symptoms of depression, anxiety and withdrawal.
Domestic violence does not always impinge equally on all children in the family. Research suggests that parental annoyance is more likely to be directed towards the temperamentally ‘difficult’ child. A further factor is that children who witness anger or violence can have difficulty in controlling their own emotions and behaviour.

| Self Care Skills | Children may be expected to take too much responsibility for themselves and they may themselves adopt a parenting role towards their abused parent | Bearing too much responsibility for their care and that of parents and siblings. |

**Stage 4: The child from 10-14 years**

<table>
<thead>
<tr>
<th>Areas of Development</th>
<th>Impacts of Domestic Violence</th>
<th>Warning Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td>Children may be left to cope alone with the physical changes that accompany the onset of puberty. If children have a parent suffering from depression brought on by domestic violence this can increase the risk of psychological problems in the child. Children may fear being physically hurt in the abusive situation.</td>
<td>a) Children may be anxious about how to compensate for physical neglect; b) Children may appear to have low self esteem; c) Fearful of getting hurt; d) Develop an early interest in alcohol and drugs.</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>The impact on children’s education/academic competence can be varied. For some children school is seen as a source of help and sanctuary from problems at home. For others they can experience an inability to concentrate causing them to perform below their expected ability. And missing school because they are caring for parents and or siblings.</td>
<td>a) School performance may be below expected ability or very much an overachiever; b) Poor school attendance record.</td>
</tr>
<tr>
<td><strong>Identity</strong></td>
<td>At this age children typically begin to question their parents’ values and beliefs. Rigid family thinking or extreme behaviour such as domestic violence may lead to rejection of the family and low self-esteem. Like younger children, adolescents can blame themselves for the</td>
<td>a) Depression and low self-esteem; b) Children may be in denial of their own needs and feelings</td>
</tr>
</tbody>
</table>
| **Family & Social Relationships** | Children can be cautious of:  
- Exposing family life to outside scrutiny and as a result friendships are restricted.  
A parent may impose isolation from peers, extended family, or outsiders. Some children may have tried to cope with the violence by running away:  
- By the age of eleven children can start a pattern of going missing.  
- Children who wander the streets are shown to be very much at risk of detachment from school and involvement in crime. | a) Friendships may have been restricted;  
b) Attempts to run away from home;  
c) Children may be cautious about discussing family life |
| **Social Presentation** | Growing up in a family where violence is an accepted way of dealing with problems can result in some children using:  
- Violent, bullying or aggressive language and behaviour towards peers or adults | Demonstrating inappropriate behaviour such as violence, bullying and sexual abuse. |
| **Emotional & Behavioural Development** | The emotional instability in children of this age means that like in younger children the impact of parental conflict may be great. Conflict between a caring role and the child’s own needs can lead to feelings of guilt and shame. Some children will demonstrate their emotions and frustrations through aggressive behaviour. | a) Overly aggressive behaviour;  
b) An inability to verbally express their frustrations and emotions;  
c) Early sexual activity |
| **Self Care Skills** | The continual fear of what might happen when they are away from the home can cause young adolescents to be:  
- Continually vigilant.  
- They may take too much responsibility for the care and protection of other family members.  
As a result they may try to be absent from home as little as possible and everyday events such as having lunch at school, visiting friends or joining school trips can be forgone causing their developmental and socialisation skills to be neglected. | a) The child appears overly anxious and unsettled;  
b) Their perceptions of risk may be particularly acute or conversely poorly reactive;  
c) The child’s capacity to engage in social interaction in a normal developmental way may have been impaired. |
# Stage 5: The child from 15 + years

<table>
<thead>
<tr>
<th>Areas of Development</th>
<th>Impacts of Domestic Violence</th>
<th>Warning signs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teenagers may:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Try to kill a parent</td>
<td>a) Inappropriate sexual behaviour or comments towards peers or adults;</td>
</tr>
<tr>
<td></td>
<td>• Become a party to, or imitating abusive behaviour</td>
<td>b) Signs of sexual aggression.</td>
</tr>
<tr>
<td></td>
<td>• Become identified with abused or abusing parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If a parent has been emotionally unavailable to a child there may not have had the opportunity to discuss contraception or how to behave in close personal relationships. Children in this situation may have grown up with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Inappropriate role models</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A poor attitude to and/ or understanding of sexual relations.</td>
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</tr>
<tr>
<td></td>
<td>This could put them at risk of:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Getting pregnant or getting someone pregnant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Or catching a sexually transmitted disease.</td>
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<tr>
<td></td>
<td>Young people need a level of self-confidence to be able to influence what happens to them in a sexual relationship and growing up with domestic violence will usually damage a young person’s self-confidence.</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>A failure to achieve education potential could lead to</td>
<td>a) Frequent patterns of disciplinary action at school;</td>
</tr>
<tr>
<td></td>
<td>• School exclusion</td>
<td>b) A history of expulsion from school.</td>
</tr>
<tr>
<td></td>
<td>• A lack of attainment that will determine future life chances.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If disturbed behaviour results in exclusion from school, teenagers need an adult to champion their cause and strive for their re-entry or ensure their learning continues. However, parents with problems may leave teenagers without a champion.</td>
<td></td>
</tr>
<tr>
<td><strong>Identity</strong></td>
<td>When young people have grown up in families where little is predictable or reliable, they are likely to believe that they have little control over what happens to them.</td>
<td>Has difficulty in making decisions and following them through</td>
</tr>
<tr>
<td><strong>Family &amp; Social Relationships</strong></td>
<td>Adolescents can feel isolated from friends and adults outside of the family. The wish to escape from parents can place young people in a very vulnerable position. Young people may attempt to</td>
<td>a) Poor social networks amongst peers and adults;</td>
</tr>
<tr>
<td></td>
<td>a) Poor social networks amongst peers and adults;</td>
<td>b) A history of running</td>
</tr>
</tbody>
</table>
withdraw and run away in a number of ways by emotionally withdrawing and spending large amounts of time on their own. Secondly there are high incidences in families with domestic violence of children actually running away. Alternatively, the young person may seek escape and solace in drugs and alcohol. The experience of domestic violence will also affect young people’s dating behaviour. Research suggests that witnessing the abuse of their mother is associated with teenage boys taking an aggressive, angry and abusing role during dates.

- Seek refuge in risk taking behaviours
- away from home;
- c) Extremely introverted behaviour;
- d) Evidence of reliance on drugs or alcohol
- e) A tendency to get serious about relationships too early in order to escape home;
- f) Over aggressive behaviour with peers and adults.

### Social Presentation

To have grown up in a culture of violence may result in young people resorting to aggression as a method of solving their own problems.

### Emotional & Behavioural Development

The tendency to blame themselves for parental behaviour continues through to late adolescence. Research suggests that children who have experienced physical and sexual abuse are at risk of suicidal behaviour, self-harming and depression.

### Self Care Skills

When away from home many teenagers continue to worry about their parents and siblings, this concern may result in young people leading a restricted life

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<tr>
<th>Social Presentation</th>
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<td>Emotional &amp; Behavioural Development</td>
<td>The tendency to blame themselves for parental behaviour continues through to late adolescence. Research suggests that children who have experienced physical and sexual abuse are at risk of suicidal behaviour, self-harming and depression.</td>
</tr>
<tr>
<td>Self Care Skills</td>
<td>When away from home many teenagers continue to worry about their parents and siblings, this concern may result in young people leading a restricted life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young people at risk of forced marriage (predominantly young women 13-21)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Areas of Development</th>
<th>Impacts of Domestic Violence</th>
<th>Warning signs</th>
</tr>
</thead>
</table>
| Health | In forced marriage one or both of the spouses do not consent to the marriage or consent is extracted under duress. Duress includes both physical and emotional pressure. Forced marriage is primarily, but not exclusively, an issue of violence against women. There is evidence to suggest that 15% of victims are males.² Young people are risk of:  
- Rape/sexual assault  
- Physical assault  
- Kidnapping | a) Substance misuse  
b) Depression  
c) Anorexia  
d) Low self esteem  
e) Reports of domestic violence or breaches of the peace at the family home  
f) Family disputes  
g) Unreasonable restrictions  
h) ‘House arrest’ |

² In cases of Forced Marriage always consult the guidance Dealing with cases of Forced Marriage (Police, Education professionals and Social workers)
http://communities.homeoffice.gov.uk/raceandfaith/faith/forced-marriages/
| **Education** | Young people at risk of forced marriage are frequently withdrawn from education, restricting their educational and personal development. These factors can contribute to:  
- Impaired social development  
- Limited career and educational opportunities  
- Financial dependence and lifestyle restrictions. |
| --- | --- |
| **Identity** | Parents who force their children to marry often justify their behaviour as protecting their children:  
- Building stronger families  
- Preserving cultural or religious traditions.  
They may not see anything wrong with their actions.  
**Forced marriage cannot be justified on religious grounds;** every major faith condemns it, freely given consent is a prerequisite of Christian, Jewish, Hindu, Muslim and Sikh marriages.  
The majority of forced marriage cases encountered in the UK involve South Asian families. However it is clear that forced marriage also involves families from East Asia, the Middle East, Europe, and Africa. |
| **Family & Social Relationships** | Isolation is one of the biggest problems facing victims of forced marriage. They may feel they have no one to talk to about their situation. For many running away may be their first experience of living away from home. For individuals, especially females from ethnic minority communities, leaving their family can be especially hard. Leaving their family may be seen as bringing shame on the honour of the individual and their family in the eyes of the community. This may lead to social ostracism and harassment from the family and community. |
| **Social Presentation** | Studies have shown that the suicide rate of young Asian women is two to three times the national average and contributory factors include lack of | | | | a) Family history of older siblings leaving education and marrying early  
b) Truancy  
c) Decline in performance/punctuality  
d) Low motivation at school  
e) Poor exam results  
f) Being withdrawn from school by those with parental responsibility  
g) Not allowed to attend extra curricular activities  
As above  
| a) Withdrawn  
b) Depression  
c) Fear, anxiety  
Self harm  
Attempted suicide |
| Emotional & Behavioural Development | Young people forced to marry, or those that fear they may be forced to marry may feel unable to against their parent’s wishes. They may appear anxious, depressed and emotionally withdrawn | As above |
| Self care Skills | Those who do leave their families to escape forced marriage often live in fear of their own families who will go to considerable lengths to find them and ensure their return. | A above |
Appendix 2

USEFUL NUMBERS

If you or clients ever feel in immediate danger, dial 999
You can also contact your local social services office or the Out of Hours social workers in an emergency, especially where children are involved.
There are a number of organisations dealing with domestic violence and supporting victims. Details are given below.

Police Service of Northern Ireland 0845 600 8000
Domestic Violence officers are available in all areas
(Ask to speak to the local Domestic Violence Officer)

Women’s Aid Federation Northern Ireland 028 90249041
Women’s Aid is the lead voluntary organisation responding to domestic violence in Northern Ireland. Its main aim is to create a safe and supportive society for women, children and young people affected by domestic violence.

National Domestic Violence Helplines
Northern Ireland 24 Hour Domestic Violence Helpline 0800 917 1414
Text-phone facility for hearing impaired callers – language line for Non-English speaking callers.

Republic of Ireland Helpline 1800 341900
Scottish 24 hour Helpline 0800 027 1234
English 24 hour Helpline 0808 200 0247
Welsh 24 hour Helpline 08457 023 468
Law Society of Northern Ireland 028 90 231614
(For details of Solicitors in areas who deal with Family law issues)

Local Women’s Aid Advice Centres

Antrim, Ballymena, Carrickfergus, Larne and Newtownabbey 028 2563 2136
Belfast and Lisburn 028 90666 049
Causeway 028 70 356573
Cookstown and Dungannon 028 86 769300
Craigavon and Banbridge 028 38 343256
Fermanagh 028 66 328898
Foyle 028 71 280060
Newry, Mourne, South Down & South Armagh 028 30 250765
North Down & Ards 028 91 273196
Omagh 028 82 241414

Men’s Organisations

Men’s Advisory Project (MAP) 028 9024 1929
This organisation provides a service to male victims of domestic violence and abuse and also offers counselling to men on anger management.

Men to Men 028 9024 7027

**Gay/Lesbian/Bisexual/Transgender Helplines**

Cara Friend
Gay helpline (Monday to Wednesday) 028 9032 2023
Lesbian helpline (Thursday evenings) 028 9023 8668
Rainbow Project 028 9031 9030

**Other Useful Numbers**

Rape Crisis and Sexual Abuse Centre 028 9032 9002
Nexus 028 9032 6803
Victim Support 028 9024 4039
Disability Action 028 9029 7880
Northern Ireland Council for Ethnic Minorities 028 9023 8645
Citizen’s Advice Bureau 028 9023 1120
Law Society (Legal and Local Solicitor Advice) 028 9023 1614
Opportunity Now 029 2043 6912
Samaritans 08457 90 9090
Parents Advice Centre 028 9031 0891
Northern Ireland Legal Services Commission 028 9024 6441
Age Concern Northern Ireland 028 9032 5055
Help The Aged (Freephone) 0808 8087575
Children In Northern Ireland 028 9040 1290
Irish Congress of Trade Unions 028 9024 7940
Law Centre 028 902444401
NSPCC 0800 800 5000
Text-Phone 0800 056 0566
Appendix 3

MULTI-AGENCY RISK ASSESSMENT CONFERENCING

What is MARAC?

MARAC is a Multi-Agency Risk Assessment conference, for victims of domestic violence.

What is its Purpose?

To make you safer

How does it work?

Agencies that support you will refer with your consent. Agencies will share information about you and your situation: who or what places you at risk of harm; what action / steps need to be taken to make you safer.

What can MARAC provide?

- They can create a safety plan for you
- Practical help to improve security in your home
- Access to other agencies: Court Support, Legal Services, and Housing etc.
- Highlight your situation with police to ensure a speedy response to any emergency which may occur

What happens after the conference?

Following discussions, the Action Plan will be shared with you and you will have the opportunity to comment. Your situation will be reviewed fortnightly until you are no longer in a high-risk situation.
Appendix 4

Safety Plans

Increasing Safety in the relationship

- Consider referral to MARAC
- Where can the victim keep important phone numbers so that they are always accessible to them and their children?
- Ask her to think of the names of two people she can tell about the abuse and ask them to listen out for strange noises from her home. So that they can call the police if she is being assaulted.
- What code word or phrase can she use in an emergency to let her children know that she wants them to get to safety immediately?
- Ask her to think of four places she can go to if she leaves her home.
- Who can she leave extra money, car keys, clothes and copies of documents with?
- What will she take with her if she leaves?
- Where can she leave an emergency bag?
- Where can she hide emergency money and important documents?
- What part of the house should she avoid when the abuse starts? Where is there no exit? Where are there things that can be used as weapons?

Increasing safety when a relationship is over

- Things that she might need straight away:
  - Change locks
  - Get smoke detectors
  - Get a security system
  - Get stronger (metal) doors
  - Get an outdoor lighting system
  - Change landline and mobile numbers
- Who will she tell that her partner no longer lives with her?
- Who will she ask to call the police if they see her partner near her home or children?
- Advise her that she should tell people who care for her children who is allowed to pick them up, and give them the names of the people she has given permission to
- Who can she tell about her situation at work and ask them to screen her calls?
- What shops, banks and other places that she used to use with her partner does she need to avoid?
- Who can she call if she’s feeling down and is tempted to return to her partner?
- Advise the woman that she should always dial 141 before calling out, so that her number can’t be traced
- Make a list of numbers including the police, a helpline, friends and a refuge or outreach centre (DOH 2005)
Appendix 5

How to use the Barnardos NI Multi-agency Domestic Violence Risk Identification Threshold Scales  Created by Maddie Bell Barnardos

The risk identification matrix is a tool to assist professionals in front line agencies who provide services for children and young people to use the available information to come to a judgement about the risk of harm to a child. This may include deciding that the available information is not enough to form a sound judgement about the risk.

Health Visitors who have not had specific training should, wherever possible, complete the risk identification matrix together with their agency’s nominated safeguarding children adviser.

A Health Visitor may have a lot or a very little information indicating that domestic violence is taking place within a family. The professional should look across the whole matrix and tick the description/s of the incidents / circumstances which correspond best to the information available at the time. This is likely to mean ticking several descriptions.

The scale headings at the top of each section indicate the degree of seriousness of each cluster of incidents / circumstances (e.g. scale 1: moderate risk of harm).

Each scale has categories to assist professionals to think through whether the information is about the:

1) **Evidence of domestic violence;**

This is the most significant determinant of the scale of risk (moderate through too severe).

2) **Characteristics of the child or situation which are additional ‘risk factors / potential vulnerabilities’;**

These are the factors that may increase the risk of children suffering significant harm through the domestic violence.

3) **Characteristics of the child or situation, which are ‘protective factors’.**

Professionals should keep in mind that protective factors may help to mitigate risk factors and potential vulnerabilities.

A family’s situation may mean that there are ticks under more than one scale heading e.g. moderate (scale 1) and moderate to serious (scale 2). Where this is the case, professionals should judge the risk to the child/ren to be at the higher level (in this case, scale 2) and plan accordingly.
Professionals should always keep in mind the possibility that a piece of information, currently not known, could significantly raise the threshold of risk for a child.

Factors which increased vulnerability / risk and appropriate interventions

Evidence from serious case review in England highlighted that babies under 12 months old are particularly vulnerable to violence. Where there is domestic violence in families with a child under 12 months old (including an unborn child), even if the child was not present, any single incident of domestic violence may fall within scale 4. (Safeguarding London’s Children: Review of London Serious Case Reviews First Annual Report Author Christine Christie May 2007)

If there are children under the age of seven in the family, this could raise the level of risk as young children are more vulnerable because they do not have the ability to implement safety strategies and are dependent on their mothers to protect them. In cases such as this, the characteristics of the child and situation, which are ‘protective’, need to be carefully considered.

If there is a child or a mother who has special needs, the risk of harm to the child, the mother and other children in the family is increased because the child or mother may not have the ability to implement an effective safety strategy.

If the mother is a vulnerable adult, professionals should follow their local Protection of Vulnerable Adults (POVA) procedure.

If the child/ren or mothers are from a black or minority ethnic community they may be experiencing additional vulnerabilities.

Violence directed towards a mother may draw attention away from the fact that a child in the family may be being sexually or physically abused or targeted in some other way (e.g. the child could be the focus of paranoid thoughts).

Professionals should also assure themselves that a child is not perpetrating abuse towards other family members.

Thresholds & interventions

UNOCINI is completed and referral through to Social Services at all threshold levels in Domestic Violence Risk Matrix.

Threshold scale 1 assesses the potential risk of harm to the child/ren as moderate. A child in this situation will have additional needs – as defined within UNOCINI. At this level early case closure will be an option for social services and supportive agencies are identified for the victim to seek support. The child/ren and their mother are likely to need family support interventions, which can be offered by the agency itself or by another single agency.
• Complete a UNOCINI and include each child in the household. If the mother does not consent to the completion of a UNOCINI, this raises the threshold. The professional should consult their agency’s nominated safeguarding children adviser and refer the family to the Trust’s Children’s Social Services
• Health Visitors should attend any meetings convened in relation to the child/family
• Follow-up to ensure that recommendations for health visiting within the UNOCINI plans have been actioned and reviewed
• UNOCINI planning must include safety planning for the child/ren and mother

**Threshold scale 2** assesses the potential risk of harm to the child/ren as moderate to serious. A child in this situation will have additional needs, as defined within UNOCINI. The child/ren and their mother are likely to need family support interventions offered by more than one agency, which are co-ordinated by Social Services

• Make a referral to trust children’s social services complete a UNOCINI and include each child in the household. If the mother does not consent to the completion of a UNOCINI, this raises the threshold. The professional should consult their agency’s nominated safeguarding children adviser and refer the family to with Trust children’s social services
• Health Visitors to attend any meetings convened in relation to the UNOCINI
• Follow-up to ensure that recommendations for health visiting within the UNOCINI plans have been actioned and reviewed.
• UNOCINI planning must include safety planning for the child/ren and mother.

**Threshold scale 3** assesses the potential risk of harm to the child/ren as serious. In threshold scale 3, protection factors are limited and the children may be suffering or be at risk of suffering significant harm. Intervention and support for the child/ren and their mother will require Trust children’s social services planning, via children in need assessment.

• Make a referral to trust children’s social services, complete a UNOCINI and include each child in the household. If the mother does not consent to the completion of a UNOCINI, this raises the threshold. The professional should consult their agency’s nominated safeguarding children adviser and refer the family to with Trust children’s social services
• Health Visitors to attend any meetings convened in relation to the UNOCINI
• Follow-up to ensure that recommendations for health visiting within the UNOCINI plans have been actioned and reviewed.
• Health Visitors should consider referring into the MARAC
• UNOCINI planning must include safety planning for the child/ren and mother

**Threshold scale 4** assesses the domestic violence as severe with increased concern regarding children’s well-being due to additional contributory risk factors. In threshold scale 4, protective factors are extremely limited and the threshold of significant harm is reached.
• The Health Visitor should make an immediate referral to Gateway team via telephone and follow up with UNOCINI within 24hrs in line with NI Regional Child Protection Procedures.
• Health Visitors to attend any meetings convened in relation to the UNOCINI
• Follow-up to ensure that recommendations for health visiting within the UNOCINI and child protection plans have been actioned and reviewed.
• Health Visitors should ensure that a referral to the MARAC process has occurred if it is available in the area
• UNOCINI planning must include safety planning for the child/ren and mother.
Appendix 6  Domestic Abuse Flowchart for Midwives

All women must be asked about domestic violence at least twice in their pregnancy 
(Routine Enquiry)
- At booking
- During postnatal period
- At any other time on cause or suspicion (Selective Enquiry)

Ask the question 
(see guideline: asking the question, possible indirect & direct questions)

Document Findings: Complete Routine Enquiry on NIMATS outpatient or postnatal menu and categorise disclosure

Disclosure or suspected Domestic Violence
- Listen & respond
- Validate disclosure
- Offer choices & support
- Consider multi-agency approach

Historical disclosure

No disclosure

Disclosure – Family receiving support from social services
- No action required - Support and advice may be offered
- Maintain vigilance during pregnancy

Initiate UNOCINI referral

Assess woman’s safety as per CAADA DASH RIC (Risk Identification Checklist)

Below high risk refer to:
- Hospital Social Worker
- Gateway Team
- CPNS

High risk refer to;
- MARAC

Safety Plans Refer to Appendix 4

Resources and Support Available Appendix 2: useful telephone numbers

Complete MHHR Available

Multi-professional approach Multi-organisational communication Review and follow up

Record Keeping
- Complete MHHR
- Routine Enquiry
- UNOCINI
- Record any further documentation in departmental confidential documentation folder

Awareness of Barnardo’s "Barnet Multi-Agency Domestic Violence Risk Identification Flow Chart" Appendix 5