Title: A study to ascertain the implementation and impact of the domestic abuse antenatal care pathway in practice and through the views and experiences of the women who have experienced domestic abuse.

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Executive Summary

Domestic abuse accounts for a quarter of all violent crimes and is known to be triggered by pregnancy. This is both a criminal and public health/community safety issue affecting the physical and mental health of families in Wales.

Evidence based minimum standards for midwives and health visitors state that all women should be routinely asked about domestic abuse in the antenatal period.

Subsequently an antenatal domestic abuse care pathway to document routine enquiry and assess risk was developed and launched in Wales, in 2005.

A four phase study was conducted to ascertain the number of pregnant women who were routinely asked about domestic abuse, the number of disclosures, referrals made and explore the views of the women and health care professionals.

In Phase One, quantitative data was collected across Wales during 2009 on the number of domestic abuse disclosures in pregnancy. Phase Two, an audit report on the number of pregnant women routinely asked about domestic abuse. Phase Three qualitative data was collected using semi-structured interviews, exploring the views of women. Phase Four explored the views and experiences of midwives and health visitors on the impact of the implementation of the antenatal domestic abuse pathway.

In 2009, there were 31,746 births in Wales and there were 322 disclosures by women of domestic abuse. The number of disclosures to births varied by health board, by between 0.2% - 6.25%. However, the health board with the lowest proportion of disclosures had the highest number of homicides. Moreover, the majority of disclosures for one Health Board were only known due to police communication and completion of Public Protection Document Form 1(PPD1).

Not all Health Boards supported midwives to attend a Multi-agency Risk Assessment Conference (MARAC). This influenced the amount of information shared with the midwife, especially via the PPD1.

Victims with a high risk score were not always referred to a MARAC as required by Standard Five of the evidenced based minimum standards.

Women felt it was the midwives' role to ask about domestic abuse. However, all the women who were interviewed stated they only disclosed once the relationship was over, as women feared the abusers' reaction to their disclosure. They also viewed pregnancy as an influencing factor on their decision to disclose.

Significant predictor factors found through logistic regression modelling as to whether the women were injured or not: if the partner had broken bail, if weapons were used, and if the victims were being abused more often. However, significant associations were also found with women who had stated they had not sustained an injury, with being threatened to be and being strangled, choked, suffocated or attempted drowning.
Significant associations between being in trouble with the police were found: between incidents resulting in an injury, the victim feeling frightened, the victim feeling isolated from family and friends, if the victim has recently separated, harassment, abuse getting worse, controlling and jealous behaviour, threats to kill the victim or someone else, attempts to strangle and choke, sexual abuse, if the partner hurt someone else, financial issues and whether their partner misuses substances or has mental health problems. However, logistic regression modelling, with the dependent variable being whether the partner had been in trouble with the police or not, found that the predictor factors were: misuse of substances or mental health problems, sexual type of abuse, and controlling/jealous behaviour.
Audit revealed that the level of enquiry varied between health boards between 24%-65%. Therefore, if extrapolated, the potential disclosures that could have happened vary between 556 -1529 being much greater than the 322 disclosures that were made. No Health Board met the minimum standard.
Health Board 5 had significantly more women who would: be injured, feel isolated, have separated or tried to separate in the last year, be stalked or harassed, have an increase in frequency of abuse, find the abuse became worse, as well as attempts to strangle/choke/suffocate/drown.
Women normalised the attacks, with responses stating that there was no injury despite being sexually abused or attempted strangulation and choking. Also, that there had not been a threat on their life but an attempt to either strangle, choke, suffocate or drown the victim.
Many significant associations were found between the abuser threatening to commit suicide and risk factors disclosed by the victim that warrant further investigation of the psychological impact of this on both the abuser and the victim.
Domestic abuse is not acceptable and more needs to be done to raise awareness and remove the shame and embarrassment that makes victims hide what is happening to them inflicted by someone who is supposed to care for them.

Key Issues to be Addressed

- Domestic abuse needs to have a higher profile within the Health Boards at an executive level, alongside child protection and protection of vulnerable adults.
- Annual audit reports on routine enquiry should be fed back to the executive committees.
- Each Health Board should have or develop a domestic abuse subgroup to address clinical practice, education and training issues. This group should take a lead role in advising the executive committee in the strategic direction within the Health Board.
- Midwives should have access to clinical supervision to address the issues and impact of working with victims and survivors of domestic abuse.
- Routine enquiry should be an element of individual performance review for all midwives.
- Domestic abuse should be included on staff induction training and included on mandatory training in high risk areas such as emergency units, mental health, community drug and alcohol teams, maternity and in primary care.
- Domestic abuse needs to be required training for occupational health personnel, human resources and counsellors within Health Boards.
- Consideration needs to be given to routine enquiry being implemented in all areas in secondary and primary health care.
- All Health Boards should have an Information Sharing policy and domestic abuse policy.
- Domestic abuse policy should identify contact leads within the Health Board to support staff who may be experiencing domestic abuse.
- Representatives of Health Boards to be part of the domestic abuse multi-agency team, particularly in response to high risk cases. Relevant professionals need to be supported in attending MARACs.
- Further investigation of the criminal history of the perpetrators, remedial actions and prevention programmes.
- Collaborative initiatives to develop rehabilitation programmes for perpetrators to deal with issues related to abuse, substance misuse and mental health.

A study to ascertain the implementation and impact of the domestic abuse antenatal care pathway in practice and through the views and experiences of the women who have experienced domestic abuse.

Background to study

Domestic violence / abuse accounts for one quarter of all violent crimes and women most likely to experience repeat victimisation (The British Crime Survey, 2009, 1997). Key findings from the Confidential Enquiry into Maternal and Child Health (2004) found that, of the 378 women that had died, 12% had reported domestic abuse to a health care professional during pregnancy and 80% under the age of 18 years had suffered abuse at home. Previous research (Mezey, 1997) has found that pregnancy acted as a trigger, with abuse often starting or intensifying during this vulnerable time. It is therefore not only a criminal statistic but it is also a public health / community safety issue, affecting the physical and mental health of local families in Wales and therefore places health professionals in a pivotal role.

Introduction

The United Kingdom (UK) Department of Health (DH, 1998) and Welsh Assembly Governments (WAG, 2005) have an aim to eliminate health inequalities and improve the health and well being of the population. This has been gathering momentum with regard to domestic abuse with a focus on multi-agency collaborations regarding prevention, protection, justice and support (Home Office Safety & Justice 2004). The Confidential Enquiry Report into Maternal and Child Health (RCOG, 2004, 2007) demonstrated that domestic abuse can start or increase in pregnancy and is associated with maternal death, alcohol, drug abuse, suicide, miscarriage, foetal injury and death. It is known that only one out of every three episodes of domestic abuse resulting in injury is reported to the police, making it the violent crime least likely to be reported to the police (British Crime Survey 1996). Studies conducted by the Perinatal Institute (2004), found that health services may be the only point of contact and chance to disclose for women seeking assistance. Women may not readily volunteer information unless asked directly, as it acknowledged that women will on average experience thirty-five episodes of violence before seeking help, (RCOG 2004, 2007). As the long-term effects of domestic abuse are low self-esteem, self blame and dependence upon the perpetrator it leads to feelings of helplessness and fear about

ending the relationship (Kirkwood 1995). It is known that abuse often increases when the abused partner is considering leaving the relationship (Bacchus 2003, Kirkwood 1995). This may cause the abuser to feel as though he is losing control. Consequently the victim may then be at an increased risk of stalking, attempted murder and murder (Jewkes, 2002). Financial implications may also increase relationship instability and isolate the victim from her family (Hunt & Martin, 2001).

A multi-agency approach requires agreed consistent use of terminology and definition. The definition for this report refers to all types of abuse and violence, according to the All Wales strategy 'Tackling domestic abuse published by the Welsh Assembly Government';

"The use of physical and/or emotional abuse, or violence, including undermining of self confidence, sexual violence or the threat of violence by a person who is or has been in a close relationship" (Welsh Assembly Government, 2005 pg6).

The report raises awareness of the complexities surrounding victim and / or perpetrator mental health, drug and alcohol issues. It has been suggested that perpetrator violence and alcohol intake is an aggravating factor, increasing physical abuse and injury to the victim (Brecklin, 2002). The literature (Golding, 1999) also suggests that mental health disorders among women who have experienced domestic abuse are higher than the normal population.

Development of domestic abuse antenatal pathway

Supported by the Welsh Assembly Government the 'All Wales Midwifery and Health Visitors Networking Group' was established January 2004, with the aim of developing an antenatal domestic abuse pathway (appendix 1), minimum standards (appendix 2) and a training tool ('Silent Tears Listening Ears') to support midwives and health visitors routinely asking all pregnant women about domestic abuse at least once in their pregnancy. Following a disclosure, midwives and health visitors follow the domestic abuse pathway 2 (DA2) to conduct a risk assessment of further serious harm or death. The pathway is a legal record of care provision which provides midwives and health visitors with an evidence-based, structured approach to

encourage disclosures and to assess the level of risk faced by the woman and unborn child (Lynch 2005, 2006). The risk assessment tool was up-dated (2009) and monitored by CAADA (Co-ordinated Action Against Domestic Abuse) and Association of Chief Police Officers (ACPO) as a universal assessment for all relevant agencies. It is considered essential that midwives and health visitors are seen as part of the multi-agency team and are able to work collaboratively, identifying risk and sharing relevant information when addressing issues around domestic abuse.

The Pathway was launched in 2005 across Wales, which involved training all midwives and health visitors raising awareness about the impact and nature of domestic abuse and the use of the Pathway. The implementation of the pathway has been evaluated by an external research consultancy reviewing professional attitudes and knowledge (WAG, 2007). It found that the care pathway, although not fully implemented, is well on the way to achieving the desired outcomes through bringing about a change in professional knowledge and culture so that domestic abuse is routinely addressed in current practice. Levels of awareness of the issues and the dangers domestic abuse present to women and their unborn child have increased as a result of the Pathway being introduced. The pathway was cited as good practice in the All Wales Strategy (2005) "Tackling Domestic Abuse: The All Wales National Strategy: A Joint Agency Approach"

Risk Assessment Tool

During this research study the risk assessment tool was updated, changing from four risk groups (very high, high, medium and low risk) to three. ACPO agreed that any disclosure of domestic abuse was a risk and should not be referred to as 'low risk', but of 'standard risk'. The new assessment tool now includes Domestic Abuse and Sexual Harassment (DASH), as well as honour based violence and forced marriage. The DASH update also changed the levels of risk to three groups:

- **High** - There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

- **Medium -** There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances e.g. failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

- **Standard** - Current evidence does not indicate likelihood of causing serious harm.

DASH also recognised that certain questions on the risk assessment tool should be considered higher risk than others, for example, attempted strangulation or choking. These questions are therefore highlighted and professionals are encouraged to use their judgement and consider a lower threshold for referral; currently fourteen positive responses to the questions would indicate referral to Multi-Agency Risk Assessment Conference (MARAC). The domestic abuse pathway was therefore up-dated (version 5, November, 2009) to the new risk assessment.

Further Development in Practice

The success of this practice has now been extended across Wales from 2008to include gynaecology, sexual health and all emergency and minor injury units; improving access to health care and an opportunity for this vulnerable group to disclose (One Wales, 2008). Domestic abuse training has improved multi- agency working, strengthening collaborations and early identification of vulnerable women.

Part two of the pathway includes risk assessment, first developed by South Wales Police. The same levels of risk can therefore be identified by health professionals and referral made to a multi agency risk assessment conference (MARAC). Conferences are held locally across Wales with regular interdisciplinary meetings for women who have been identified as very high risk or who are living in potentially dangerous situations (Robinson 2004). MARACs also have the parallel function of providing an environment where the safety and needs of children are discussed. Where children are involved, their needs and welfare are paramount.

Rationale

Domestic abuse is not a new phenomenon, but introducing routine enquiry into a health care setting is a new development, exposing many challenges to be met by a multi–agency response. Nicoladis (2002) suggests that there are likely benefits for the professional and the victims, around awareness, safety and support. The National Institute of Clinical Excellence (2008) antenatal care guideline identified that health professionals need to be alert to the possibility of domestic abuse. It also emphasised that there is currently:

> "Insufficient evidence on the effectiveness of intervention in improving health outcomes for women who have been identified"
>
> 7.6 pp118

Although the domestic abuse pathway has been supported by the Welsh Assembly Government and has been extended across Wales and to include all Emergency departments there is currently no research to support routine enquiry.

Consequently, it was important to ascertain the outcome of disclosure following routine enquiry on the client, whether disclosure improved their experiences, access to services and agencies and have the interventions been appropriate.

Aim and Objectives

The aim of this study was to evaluate the routine enquiry care pathway for domestic abuse in current practice.

The objectives of the study were to:

- Establish the prevalence of disclosures of domestic abuse during the antenatal period.
- Ascertain the level of risk of the women who disclose during the antenatal period.
- Map the care pathway of those who have disclosed.
- Ascertain the beneficial and detrimental experiences of women who disclose.

- Ascertain the impact and support required by health care professionals in the implementation of routine enquiry for domestic abuse.
- Establish the rationale for non adherence to the care pathway
- Make recommendations to improve education and future care provision.

Design and Methods

The study design used mixed methodologies to achieve the objectives of the research.

Phase One of the study viewed the input and collation of information from all domestic abuse disclosures in Wales in the antenatal period from the 1st January – 31st December 2009. Data included the level of risk identified following professional assessment, documented on part two of the pathway; this also included referral options and process.

Phase Two was an audit in each of the Health Boards of 100 maternity files to assess the proportion of women who had been asked at least once about domestic abuse in pregnancy.

Phase Three was semi-structured interviews of those who had disclosed to explore personal perspectives from a sample of clients:

- High risk referred to MARAC
- Medium risk
- Standard risk

Information was gathered on the experience and views of women following a disclosure and their personal views on the impact this has had on their lives and their experiences including contact with different agencies.

Phase Four explored the views and experiences of health care professionals on the impact of the implementation of the care pathway in practice. This was gathered at regional meetings across Wales, which are held to monitor and support midwives and health visitors implementing the pathway.

Populations

Wales has a birth rate of approximately 30,000 births per year. During pregnancy, the standard is that all women are routinely asked about recent experience of domestic abuse. If a disclosure is made, part two of the routine enquiry pathway is completed,

including the level of risk and referral(s) made; both are evidenced in the main hospital records. In Wales, there are 1,500 midwives and 900 health visitors who have representatives who meet together on a regional basis to discuss issues pertaining to the implementation of the care pathway for domestic abuse who participated in phase four of the study.

Procedures

Phase One

Part one of the domestic abuse care pathway collected evidence from midwives across Wales who were routinely asking women about domestic abuse in pregnancy. Following a disclosure of domestic abuse all completed Pathway 2 forms were anonymised and entered onto a database by the identified lead midwife in each Health Board. A staff protocol (appendix 3, version 2, dated 08.12.08) was sent to explain the procedure for data entry. The database included the level of risk and details of referral. Data was collected for one year, January 1st – December 31st 2009, on those women who had made domestic abuse disclosures in Wales. Within the care pathway there is documentation to be completed by midwives and health visitors following enquiry about of domestic abuse.

Phase Two

Annually, a random sample of 100 postnatal records in each of the Health Boards are examined to ascertain the proportion of women asked about domestic abuse in the antenatal period.

The audit figures on the percentage of those asked and those who have disclosed are collected by the named domestic abuse midwife. However, the detailed information on part two of the pathway was also collated and analysed.

Pathway 2 gave information on:

- Unidentifiable demographic details such as, age and area.
- the date of disclosure
- level of risk identified
- which agency client has been referred to
- appropriateness of referral depending on the risk identified, that is high, medium, or standard.

- consistency of pathway management.

Phase Three

A random selection of women who had disclosed were approached and informed about the research by the professionals involved or the domestic abuse agencies (if involved). Following agreement to participate, their contact details were forwarded to the researcher. The researcher made safe contact with them with regards to recruitment and consent into the study. Although the clients were known to other professionals or agencies, it was only the researcher who was involved in the consent, interviews and the experiences disclosed. This confidentiality was maintained throughout the research study.

The researcher conducted semi-structured interviews to explore women's experiences since disclosing domestic abuse within the selected categories (high, medium and standard risk.

Interviews were conducted with consenting participants between three to six months following the disclosure. The venue for the interview was chosen by the client to ensure personal comfort and safety. A semi-structured interview schedule (Appendix 4 version 3, 08.12.09) was developed to elicit information on the positive and negative experiences that the women may have experienced as a result of contact with agencies, the sequence of events and the impact of disclosure has had on their lives. The interviews were hand written or taped, if the participant gave permission.
Referrals were received from a variety of settings; midwives, health visitors, multi-agency risk assessment conferences and agencies supporting women post disclosure. Following consent**,** clarity was sought on their views at the end of each interview when a summary of the points was be made and agreement gained from the client as to researcher's correct understanding.

Phase Four

Midwifery and health visitor representatives meet on a regional basis for ongoing support and supervision twice a year. This platform was utilised for a focus group to elicit information on the impact and support required by health care professionals regarding the implementation of routine enquiry for domestic abuse in Wales.

Data analysis

All information was anonymous at source of entry and given identity and episode numbers. It was inputted onto the SPSS database and analysis included descriptive statistics and inferential statistics used to examine association between appropriate variables, gathered from the routine enquiry documentation. Logistic regression was used to model the probability of predictor factors of events occurring.

The taped interviews were transcribed and content analysis used to examine common themes emerging from the interview process and allow triangulation with the statistical information.

The patient journey from disclosure was mapped to explore which agencies were felt to be the most helpful.

A random sample of interviews was cross-checked by an external researcher to ensure reliability of results.

Research Governance and Ethical Approval

Confidentiality and safety was the prime focus during this research project.

Research governance and ethics approval was sought and gained from the National and Health Board Committees.

South East Wales Research Ethics Committee: 09/WSE04/36

Cwm Taf Health Board: CT/030/08

All tapes of interviews were destroyed on completion of the research study. All documentation was kept in locked cupboards according to research governance regulations. It was made clear to all interviewees that they could withdraw their consent and terminate their involvement in the project at any time without giving reason. No participants did withdraw. Post interview support was offered to participants, although this was not required.

The study has been conducted between January 2009 – June 2010.

Results

Phase One - Disclosures

During 2009, there were 31,746 births in Wales.

There was also documented evidence that 1% (322) of pregnant women disclosed information on their experience of domestic abuse during the year 2009 (Table 1). The number of disclosures to births varied across Health Boards (0.2% - 6.25%).

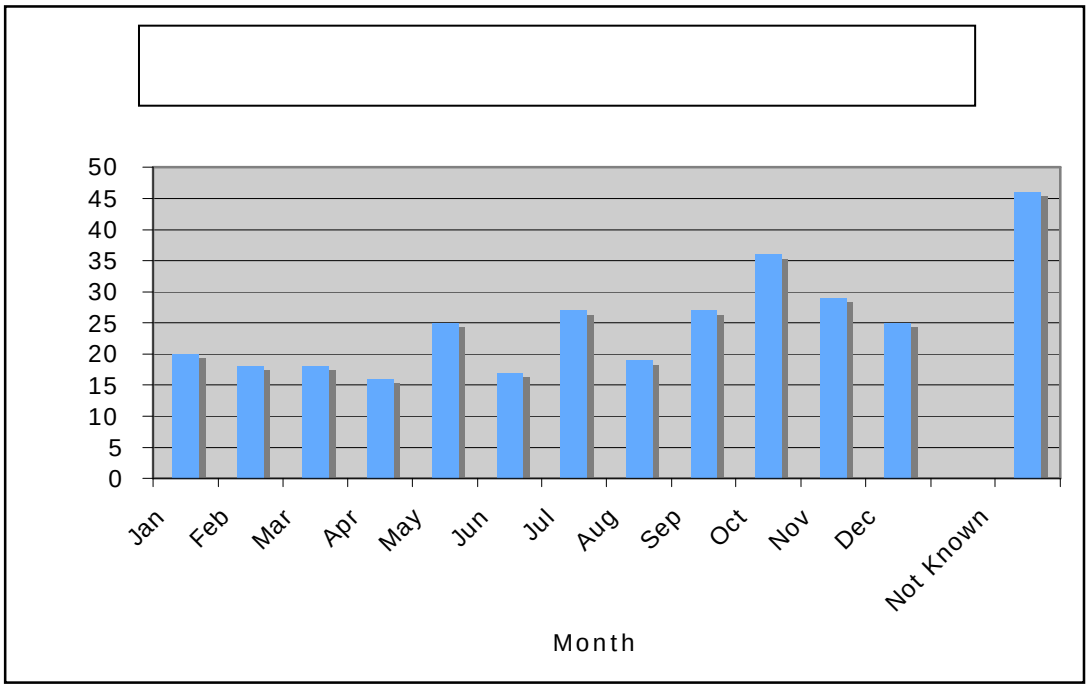
Table 1 indicates that the majority of the women who had disclosed were referred to health visitors. However, the women who had disclosed were also referred to other agencies.

Table 1: Percentage of women routinely asked, disclosures and referrals

Health Board	Births	Disclosures	Referred to Health Visitor	Referred to other agency
1.	6,500	15 (0.2%)	15 (100%)	15 (100%)
2.	6,187	33 (0.5%)	33 (100%)	33 (100%)
3.	4,974	36 (0.7%)	34 (94%)	21 (58%)
4.	6,223	124 (2%)	116 (94%)	109 (87%)
5.	4,186	92 (2%)	89 (97%)	66 (72%)
6.	3,500	11 (0.3%)	11 (100%)	7 (64%)
7.	176	11 (6.25%)	11 (100%)	12 (92%)
Total	31,746	322		

It can be seen in Figure 1 that there is a variation in the number of disclosures each month with October being the highest and April the lowest. There were significantly more disclosures recorded in the winter months October to December ($\bullet^2$=10.232, df 3, p=0.017).

Figure 1: Number of domestic abuse disclosures per month



Age

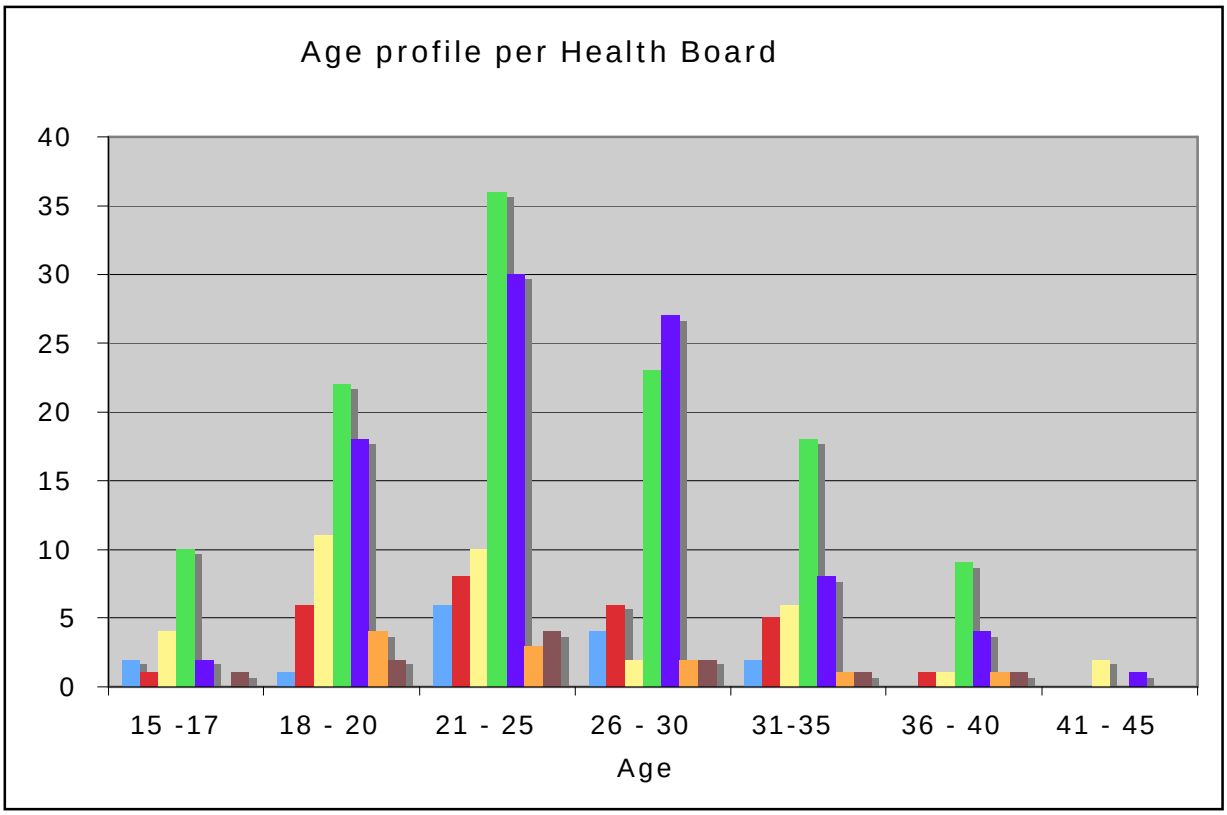
Table 2 shows the age profile of those who had disclosed within each of the Health Boards. It can be seen in Table 2 that the majority of females disclosing domestic abuse were aged 35 or younger (289, 90%).

Table 2: Age Profile of females who disclosed

Health Board	15 – 17 years	18 – 20 years	21 – 25 years	26 – 30 years	31 – 35 years	36 – 40 years	41 – 46 years	Not Known	Total
1	2	1	6	4	2	0	0	0	15
2	1	6	8	6	5	1	0	6	33
3	4	11	10	2	6	1	2	0	36
4	10	22	36	23	19	9	0	5	124
5	2	17	31	27	8	4	1	2	92
6	0	4	3	2	1	1	0	0	11
7	1	2	4	2	1	1	0	0	11
Total	20	63	98	66	42	17	3	13	322

Viewing the age profile of those who have disclosed by their Health Board, Health Board 4 had the highest number of disclosures in the 25 and younger age groups (Figure 2). Health Board 5 had high levels of disclosures in the 18-20 and 21-25 age groups and also in the 26-30 years group.

Figure 2: Age profile matched to Health Boards



KEY	COLOUR	KEY	COLOUR
1	Light Blue	5	Dark blue
2	Red	6	Orange
3	Yellow	7	Brown
4	Green		

Risk

The following information is based on the data gathered on the risk assessment form from individual Health Boards. Part 2 (DA2) of the pathway and is completed when a woman discloses domestic abuse. This is a multi-agency tool developed by CAADA

(Co-ordinated Action Against Domestic Abuse) and Association of Chief Police Officers (ACPO). There are twenty-four questions on the tool for agencies outside the police (the police ask three more regarding child protection). The questions in bold signify that they are classified as higher risk of assault or death to the individual who discloses a positive response. Referrals to a MARAC may be required for questions on the Part 2 of the Pathway that are in bold which are considered higher risk and therefore relies on professional judgement due to the lower threshold of risk.

The 24 questions asked following a disclosure can be seen in Appendix 1.
The response to these questions by the 322 respondents can be seen in Tables 3-8 below.

Response to Risk Assessment questions

Question 1: Has the incident resulted in injury?

As demonstrated in Table 3 in response to question 1, 63 (20%) of those who disclosed had stated that they had received an injury as a result of a domestic incident. These injuries were a result of being assaulted, kicked, kicked in the abdomen and slapped. It is known that 145 (45%) stated that they had not received an injury as a result of an incident but of these 23 were frightened of violence or violence to the child and 1 was afraid of death. Moreover, 27 had been threatened to be killed ($\bullet^{2} =$ 0.002, df=1), 24 strangled or choked ($\bullet^{2}$= 0.008, df=1) and 10 had been sexually abused.

Significant association was also found between sustaining an injury and: the abuse happening more often ($\bullet^{2}$ =0.002); abuse getting worse ($\bullet^{2}$ =0.004, df=1); use of weapons or objects ($\bullet^{2}$ =0.001, df=1); breaking bail or injunction (FE = 0.002); and the partner being in trouble with the police or having a criminal history ($\bullet^{2}$ =0.014, df=1). However, there were 114 (35%) cases when the response to the question was not known due to information being disclosed to other sources and not recorded by the midwife.

The dependent variable for the logistic regression model was whether the woman is injured or not. The following variables were found to be significant predictors for injury: q23 (broken bail) the odds of injury if has broken bail is 9.954 (95% CI 2.85,

34.8; •^{2}=12.95, df=1, p<0.001); q13 (weapons) the odds of injury if weapons used is 3.896 (95% CI 1.689, 8.989; •^{2}=10.161, df=1, p=0.001); q10 (abuse more often) the odds of injury if abused more often is 2.697 (95%CI 1.416, 5.140; •^{2}=9.113, df=1, p=0.003)

Question 2: Are you frightened?

There were 73 (23%) of women who were frightened; 34 of violence; 1 violence and mental abuse; and 2 of death or being killed. However, there were 136 (42%) responses that were not known. There were 132 cases where the response to this question was not known due to the disclosure not being made to the midwife. The lack of information on 113 people from Health Board 4, was due to 108 cases of disclosure being made to the police completing a PPD1 form, and 5 in the A&E department and then referred onto the midwife.

Of the 73 who were frightened: 46 (63%) had partners who had been in trouble with the police or had a criminal record (•^{2}<0.001, df=1); 8 (11%) had broken bail (FE=0.015); 26 (36%) had a partner who misused drugs or had a mental health problem (•^{2}<0.001, df=1); and 15 (21%) had partners who had threatened to commit suicide (•^{2}<0.001, df=1).

Question 3: What are you afraid of?

When women were asked what they were afraid of there were a range of responses including violence, mental abuse, violence to a child, deportation and death. Examples of responses are shown in table 3.

Question 4: Do you feel isolated from family and friends?

There were 51 (16%) women who felt that they had been isolated from family and friends (Table 3). Of these 51 women: 43 (84%) had separated or tried to separate in the last year, 37 (72%) felt controlled or received excessive jealousy, 34 (67%) were frightened, 29 (57%) had a partner in the last year who had an issue substance abuse and/or mental health, 21(41%) the abuse was getting worse and 20 (39%) had been strangled or choked. Significant association was found between feeling isolated and their partner threatening to commit suicide (•^{2}=0.001, df=1) and being in trouble with the police (•^{2}<0.001, df=1).

Table 3: Responses to Risk Assessment Questions 1-4 by Health Board

Health Boards (disclosures)	Question 1	**Question 2**	Question 3	**Question 4**
1.(15)	1	6	Death	2
2.(33)	18 *1	4 *7	Violence Mental abuse	3 *7
3.(36)	11 *5	13 *8	Partner Violence	11 *5
4.(124)	6 *108	6 *113	Being deported	7 *113
5.(92)	24	32	Death	23
6.(11)	2	5	Violence to child	0
7.(11)	1	7	Violence	5
Total	63 (20%)	73 (23%)		51 (16%)

* Missing data or not known

Question 5: Are you feeling depressed or having suicidal thoughts?
Thirty four (11%) respondents said they felt depressed or have had suicidal thoughts (Table 4). However, it has to be considered that information was missing or not known for 130 (40%) of those who had disclosed. Of those who were feeling depressed: 22 (65%) were frightened; 20 (59%) were in a controlling/jealous relationship; 12 (35%) had a partner who had threatened to commit suicide (•^{2}=0.001, df=1); and 5 (15%) had broken bail (FE=0.015).

Question 6: Have you separated or tried to separate from him within the past year?
There were 116 (35%) who had separated or tried to separate from their partner in the last year (Table 4). 59 (51%) of these were within Health Board 5. Issues associated with separation were: 69 (59%) substance misuse or mental problems (•^{2}<0.001,

df=1), 60 (52%) had problems with controlling and/or jealous behaviour, 59 (51%) had a partner with a criminal history ($\bullet^2$ =0.005, df=1), 41 (35%) had conflict over a child. However, other issues related to separation were: abuse getting worse (38, 33%), more often (33, 28%), threats to kill (33, 28%) and strangulation/choking (33, 28%); and 27 (23%) threats to commit suicide by their partner ($\bullet^2$ =0.003, df=1).

Question 7: Is there conflict over child contact?

There were 53 (16%) who were experiencing conflict over a child (Table 4). Of the 53 women who had conflict over a child: 31 (58%) of their partners had a criminal history; 25 (47%) were controlling/jealous behaviour; 24 (45%) felt frightened; 22 (42%) substance and mental health issues; 19 (36%) harassment; 18 (34%) experienced strangulation and choking and one was associated with animal cruelty.

Question 8: Does he constantly text, call, contact. Follow, stalk or harass you?

Forty four (14%) of women who disclosed stated that they felt harassed due to texting, calling and contact from their male partner (Table 4). There were 35 (80%) who had separated or tried to separate in the last year; 30 (68%) had experienced controlling/jealous behaviour; 24 (55%) had a partner with a criminal history ($\bullet^2$ =0.025, df=1); 22 (50%) felt frightened and isolated; and 16 (36%) partners had partners who had threatened to commit suicide ($\bullet^2$<0.001, df=1).

Table 4: Responses to Risk Assessment Questions 5-8 by Health Board

Health Boards	Question 5	**Question 6**	**Question 7**	**Question 8**
1	3	10	4	0
2	5 *12	9 *13	3 *13	0 *13
3	10 *5	12 *5	6 *5	11 *5
4	0 *113	10 *113	3 *113	0 *113
5	11	59	28	23
6	3	7	4	4

7	2	9	5	6
Total	34 (11%)	116 (36%)	53 (16%)	44 (14%)

Question 9: Are you pregnant or have you recently had a baby (within the last 18 months)?

As this enquiry about domestic abuse was supposed to be in the antenatal period it was not surprising that 321 of the pathway 2 of the care pathway, was completed during this period. However one was completed during the postnatal phase.

Question 10: Is the abuse happening more often?

There were 56 (17%) of women who disclosed that they were suffering abuse more frequently (Table 5). Of these there were 35 (63%) women who also felt isolated and suffered from controlling/jealous behaviour; 34 (61%) were suffering worse abuse; 33 had separated or tried to separate in the last year; 31 (55%) felt frightened; 29 (52%) had substance or mental health issues and 27 (48%) partners had a criminal record.

Question 11: Is the abuse getting worse?

There were 54 (17%) of respondents who felt that the abuse was getting worse (Table 5). In 39 (72%) of cases controlling and jealous was linked to abuse getting worse. Other issues included: more abuse 35 (65%); separation 35 (65%); substance misuse or mental health 34 (63%) ($\bullet^2$=0.006, df=1); frightened 33 (61%); and criminal history 27 (50%). There were 28 (52%) cases referred to MARAC.

Question 12: Does he try to control everything you do and / or are they excessively jealous?

This question asks the professional to consider honour based violence (HBV), including violence from a family member.

Controlling and jealous behaviour was reported by 80 (25%) of the women who had disclosed (Table 5). Of those: 60 (75%) had separated or tried to separate in the last year; 49 (61%) were frightened 24 (49%) of whom were frightened of violence; 48 (60%) of their partners had a criminal history ($\bullet^2$<0.001, df=1); 46 (58%) had a partner that misused substances or had a mental health problem ($\bullet^2$=0.013, df=1); 39

(49%) felt isolated from friends and family; 35 (44%) were suffering more abuse; 28 (35%) had been strangled or choked; 25 (32%) had been threatened to be killed; 25 (32%) had experienced conflict over a child; and 21 (26%) had a partner who had threatened to commit suicide (•^{2}<0.001, df=1).

Table 5: Responses to Risk Assessment Questions 9-12 by Health Board

Health Boards	**Question 9**	**Question 10**	**Question 11**	**Question 12**
1	15	6	6	5
2	32 + 1 postnatal	5 *12	6 *12	6 *12
3	36	19 *5	14 *5	16 *5
4	124	2 *113	8 *113	8 *113
5	92	20	16	35
6	11	1	1	4
7	11	3	3	5
Total	322	56 (17%)	54 (17%)	80 (25%)

Question 13: Has he ever used weapons or objects to hurt you?

There were 22 (7%) respondents who stated that weapons or objects had been used to hurt them. 15 (68%) of these had been threatened to be killed; 15 (68%) had separated or tried to separate in the last year; 13 (59%) of their partners had a criminal history but only 2 had broken bail; 13 of their partners had a substance misuse or mental health problem; 12 (55%) had also been strangled and choked; and 12 (55%) were jealous and controlling behaviour. 17 (77%) women were referred to MARAC.

Question 14: Has he ever threatened to kill you or someone else and you believed them?

There were 43 (13%) who believed that they or someone else had been under threat of being killed by their partner. 33 (77%) respondents had separated or tried to separate

in the last year from their partner. It was found that: 30 (70%) of their partners had a criminal history ($\bullet^2$<0.001); 30 (70%) had a misuse of substance or mental health problem ($\bullet^2$ =0.001, df=1); 26 (60%) felt they were in a controlled/ jealous relationship; 24 (56%) had been strangled and/or choke; 16 had threatened to commit suicide ($\bullet^2$<0.001, df=1); and 5 had broken bail (FE =0.048). 21 (49%) of these women were referred to MARAC.

Question 15: Has he ever attempted to strangle/choke/ suffocate/drown you?

Attempted strangle/choke/suffocation had been experienced by 40 (12%) of the women who had disclosed (Table 6). Of those who disclosed: 35 (88%) had separated or tried to separate in the last year; 30 (75%) had a partner with a criminal history ($\bullet^2$<0.001, df=1); 28 (70%) were in a controlling/jealous relationship; 28 (70%) had a partner with misuse of substances or mental health problem ($\bullet^2$ = 0.002, df=1); 26 (65%) were frightened of their partner; 24 (60%) had been threatened or someone else had been threatened to be killed; 14 (35%) had a partner who had threatened to commit suicide ($\bullet^2$ =0.001, df=1); and 5 (13%) had broken bail (FE=0.007). There were 23 (58%) referrals to MARAC.

Question 16: Does he do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else?

There were 13 (4%) who had abuse of a sexual nature either verbally or physically (Table 6). Of these: 10 (77%) had a partner that misused substances or had a mental health problem ($\bullet^2$ =0.032, df=1); 9 (69%) were in a controlling/ jealous relationship; 8 (62%) had a criminal history; 8 (62%) had separated or tried to separate in the last year; 8 (62%) were suffering more abuse recently; and 6 (46%) had a partner threatening to kill them or others. There were 9 (69%) of these cases referred to MARAC.

Table 6: Responses to Risk Assessment Questions 13-16 by Health Board

Health Boards	**Question 13**	**Question 14**	**Question 15**	**Question 16**
1	0	5	2	2
2	2	0	1	1

	*13	*13	*13	*13
3	4 *5	7 *5	3 *5	4 *5
4	1 *113	5 *113	4 *113	0 *113
5	12	21	21	5
6	1	2	4	0
7	2	3	5	1
Total	22 (7%)	43 (13%)	40 (12%)	13 (4%)

Question 17: Is there any other person who has threatened you or who you are afraid of?

This question asks the professional to consider honour based violence (HBV).

There were 6 cases who reported that there was another person who had threatened them or who they were afraid of. These were associated with: 5 (83%) with threat to kill; 5 experience of being strangled/choked; 5 were separated or tried to separate in the last year; 4 (67%) frightened; 4 controlled and jealous situation; 4 substance and mental health problems; and 4 had a criminal history.

Question 18: Do you know if he has hurt anyone else?

This question asks the professional to consider honour based violence (HBV).

In 13 cases it was known that the women's partner had injured somebody else (Table 7). In 12 (92%) of these cases it was known that the woman had separated or tried to separate from her partner in the last 12 months and they were in a controlling/ jealous relationship. 11 (85%) of their partners had a criminal record ($\bullet^2$=0.001, df=1); and 5 had broken bail (FE=0.023). It was also known that: 10 (77%) misused a substance or had a mental health problem ($\bullet^2$=0.032, df=1); 9 (69%) of their partners had threatened to commit suicide (FE<0.001); 9 of the women were frightened; 9 felt isolated from family and friends; and 9 were suffering from harassment.

Question 19: Has he ever mistreated an animal or the family pet?

There were only 2 instances that mistreatment of a family pet had occurred (Table 7). Both of these cases were associated with isolation, separation, harassment, control and jealousy, threat to kill, strangulation/choking, substance misuse or mental health issues, threat to commit suicide (FE=0.027), criminal history, broken bail (FE=0.002) and injury to others. Both of these cases were referred to MARAC.

Question 20: Are there any financial issues?

Only 18 (6%) of the abused women stated there were financial issues (Table 7). It was found that: 14 (78%) who reported financial issues had separated or tried to separate in the last year; 13 (72%) had a partner with a criminal history ($\bullet^2$ =0.011, df=1); 12 (67%) were in a controlling/jealous relationship; 12 (67%) had a partner who abused substances or had a mental health problem; 11 (61%) were frightened; 10 (56%) were feeling depressed or had suicidal thoughts; 8 (44%) had a partner who had threatened to commit suicide (FE=0.005) and 4 had broken bail (FE=0.010). 11 (61%) had been referred to a MARAC.

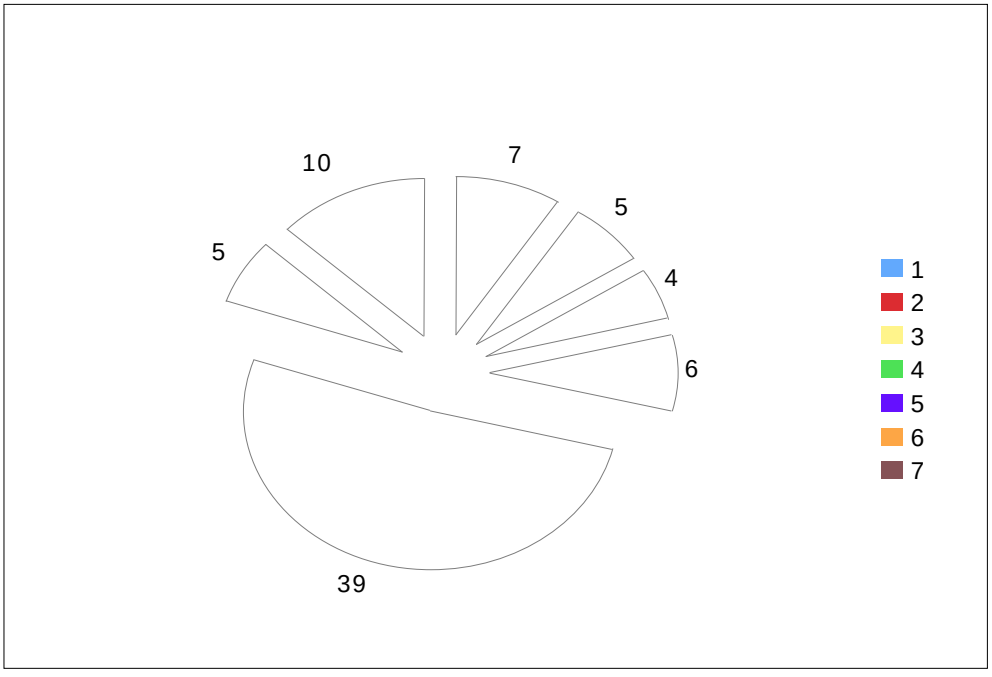
Table 7: Responses to Risk Assessment Questions 17-20 by Health Board

Health Boards	**Question 17**	Question 18	Question 19	Question 20
1	1	1	0	1
2	0 *13	0 *13	0 *13	1 *13
3	3 *5	5 *5	0 *5	3 *5
4	0 *113	0 *113	0 *113	0 *113
5	1	4	2	9
6	1	2	0	3
7	0	1	0	1
Total	6 (2%)	13 (4%)	2 (0.6%)	18 (6%)

Question 21: Has he had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life?

There were 92 (29%) who had a partner who had misused substances or had mental health problem, however this information was not known for 131 (41%) of women who had disclosed. Of these 92: a high proportion, 69 (75%) had separated or tried to separate from their partner during the last year; 60 (65%) had a partner with a criminal record ($\bullet^2$<0.001, df=1); 47 (51%) were frighten, 27 of violence and 1 of death; 46 (50%) were in a controlling/jealous relationship; 34 (37%) the abuse had been getting worse; 30 (33%) had been threatened to be killed; 28 (31%) strangled or choked; and 22 (24%) involved conflict over a child; 22 (24%) had a partner who had threatened to commit suicide ($\bullet^2$=0.011, df=1) and 8 (9%) had broken bail (FE=0.008). 40 (43%) cases were referred to MARAC. Table 8/Figure 3 demonstrates that Health Board 5 has a higher level of substance misuse and mental health problems associated with domestic abuse (45, 49%). These figures, although different are similar to Health Board 6 (5 (45%) of those that disclosed.

Figure 3: Perpetrator and substance misuse or mental health problem by Health Board



Question 22: Has he ever threatened or attempted suicide?

There were 32 (10%) of the partners of those who had disclosed who had threatened to commit suicide (Table 8). 27 (84%) whose partners had threatened suicide had separated or tried to separate in the last year. 26 (81%) were in a controlling/jealous relationship. 25 (78%) had a criminal record and 22 had a history of mental health and/or substance misuse. 19 (59%) of these cases had been referred to a MARAC.

Question 23: Has ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children?

There were 10 (3%) people whose partners had broken bail or formal agreement over access, 2 had a conflict over a child. However, it was found that: 9 (90%) of their partners had a criminal history; 9 (90%) substance misuse or mental health problem; 7 (70%) had experienced an incident that had resulted in an injury; 7 (70%) were frightened of violence; 7 (70%) had separated or tried to in the last year; 6 (60%) had been strangled or choked; and 5 (50%) had been threatened to be killed

Question 24: Do you know if he has ever been in trouble with the police or has a criminal history?

There were 78 (24%) who had a partner who had been in trouble with the police or had a criminal record (Table 8). It was found that: 60 (77%) had a partner with mental health or substance misuse problem; 57 (73%) had separated or tried to separate in the last year; 48 (62%) were in a controlling relationship; 46 (59%) were frightened; 39 (50%) were referred to a MARAC; and 32 (41%) felt isolated. 30 (38%) had been threatened to be killed and 30 (38%) had experienced an attempt to strangled, choked, suffocated or drown. However, only 18 (60%) of those who had experienced an attempt on their life considered this as a treat to be killed. As demonstrated in Figure 4, Health Board 5 has the highest number of perpetrators who have been in trouble with the police or have a criminal history. However, it has to be considered that this information was not available for 113 cases recorded for the Health Board 4.

Also, a logistic regression model was performed with the dependent variable being whether the partner had been in trouble with the police or not. The following variables are significant predictors for being in trouble: q21 the odds of being in trouble if the abuser misused substances or had a mental health problem is 7.426 (95% CI 2.683,

20.553; •^{2}=14.908, df=1, p<0.001); q15 the odds of being in trouble if sexually type of abuse is 3.777 (95% CI 1.05, 13.585; •^{2}= 4.144, df=1, p=0.042); q12 the odds of being in trouble if a controlling jealous type of person is 3.425 (95% CI 1.226, 9.564; •^{2}=5.516, df=1, p=0.019)

Figure 4: Perpetrators with a criminal history by Health Board

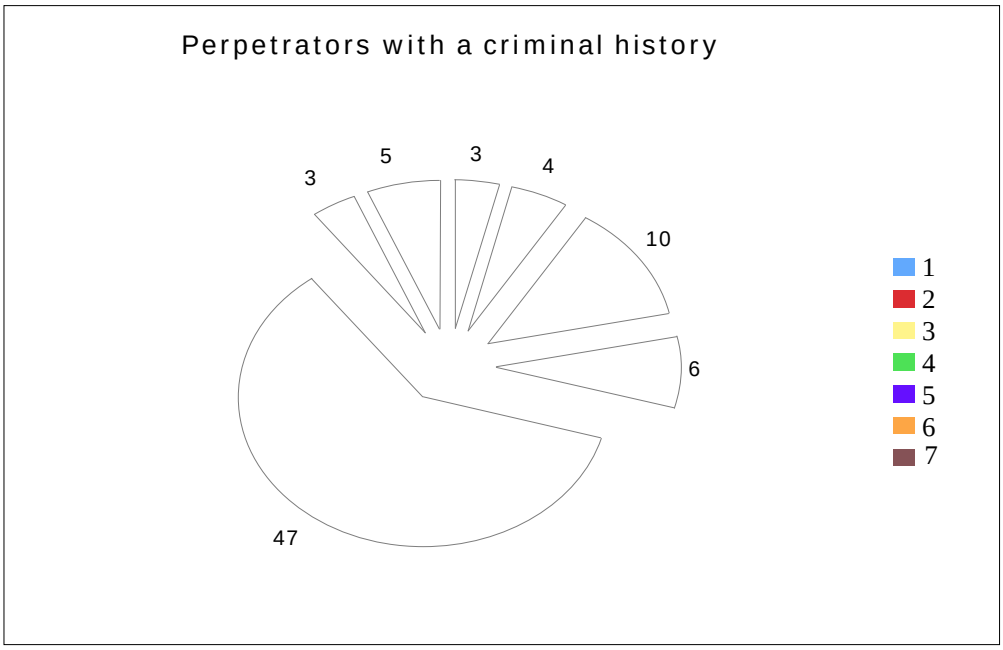


Table 8: Responses to Risk Assessment Questions 9-12 by Health Board

Health Boards	Question 21	Question 22	Question 23	Question 24
1	6 (3A 4D 1MH)	1	1	3
2	6 (4A 1D 1MH) *13	1 *13	0 *13	4 *13
3	13 (4A) *5	9 *5	0 *5	10 *5
4	8 (4A 2D 3MH) *113	0 *113	0 *113	6 *113
5	45 (25A 14D 12 MH)	16	8	47
6	5 (4A 1D)	2	1	3
7	9 (8A 2D 3MH)	3	0	5

Total	92 (28.5%)	32 (9.9%)	10 (3.1%)	78 (24.2%)

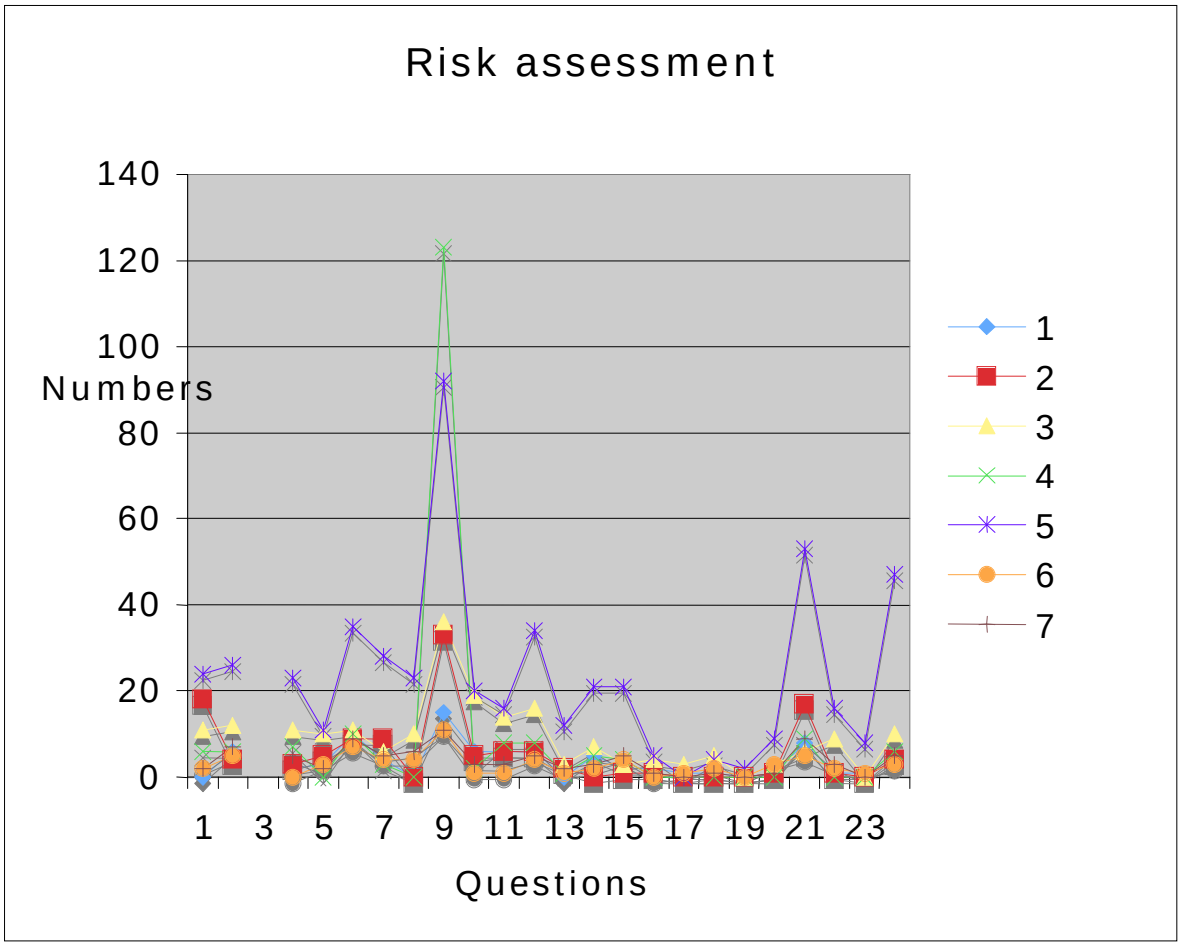
Key

Aggravating factors with perpetrator

A = Alcohol MH = Mental Health D = Drugs

The responses to the individual questions have already been reported but are presented visually in Figure 5. As can be seen the response to question 9 of being pregnant was positive for all bar one who disclosed in the post natal period. The figure below shows 4 distinct peaks to question 6 on separation, question 12 on controlling and jealous behaviour, question 21 on misuse of substances and/ mental health problems and question 24 on criminal history particularly in Health Board 5.

Figure 5: Responses to Questions on Risk Assessment Tool by Health Board



Levels of Risk

Of the 322 women who disclosed domestic abuse, Table 9 shows the levels of risk and the numbers of referrals to MARAC for each of the Health Board. As can be seen there were 62 (19%) of those who disclosed that were considered at high or very high risk. 52 (84%) of these were from the Health Board 4 who were considered at high risk, only 19 (36%) were referred to a MARAC. However, there were also 34 (27%) of women referred to the midwives where there was not information or indication of risk. Whereas, those assessed as at high risk of death or severe harm from the other health boards were all referred to a MARAC.

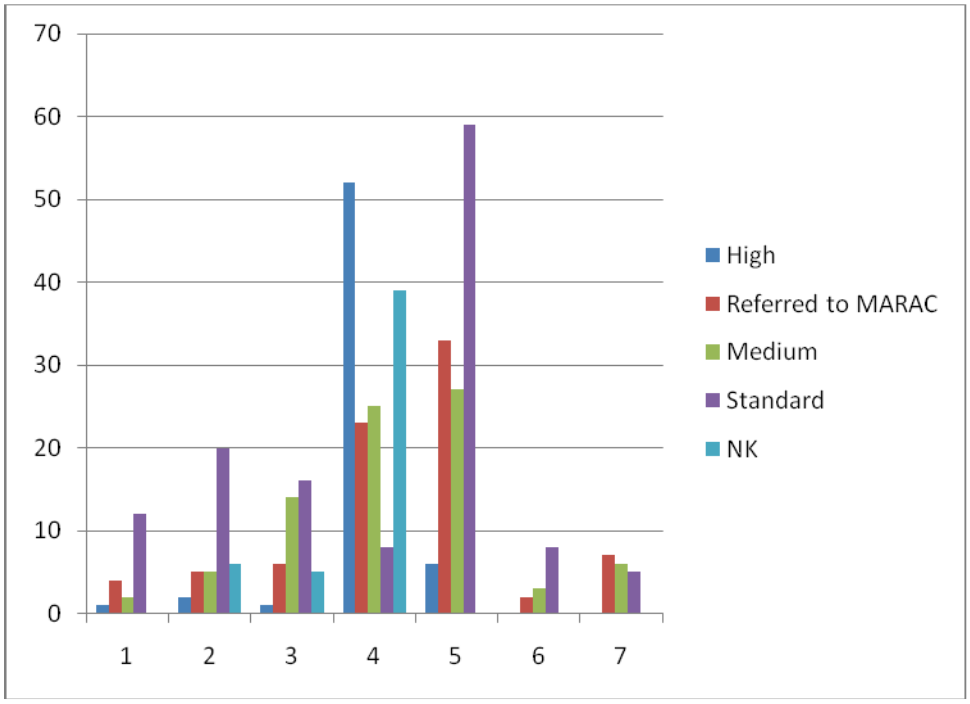
Table 9: Levels of risk and referrals to MARAC

Health Board	HIGH	REFERRED MARAC	MEDIUM	STANDARD	NK	TOTAL
1	1	(4)	2	12	0	15
2	2	(5)	5	20	6	33
3	1	(6)	14	16	5	36
4	52	(23)	25	8	39	124
5	6	(33)	27	59	0	92
6	0	(2)	3	8	0	11
7	0	(7)	6	5	0	11
Total	62 (19%)	80 (25%)	83 (26%)	127 (39%)	50 (16%)	322

As can be seen visually (Fig. 6) Health Board 4 has highest level of risk reported at a high level and also the largest number of not known / missing data. Whereas, Health Board 5 has a high proportion that disclosed but were reported to be at a standard level of risk.

During the study period there were 7 homicides due to domestic abuse (5 within Health Board 1, 1 within Health Board 4,and 1 within Health Board 5).

Figure 6: Level of risk and MARAC referrals per Health Board



Key

High =/> 14

Medium => 7

Standard = 1 – 6

Referrals

Pregnant women were referred to the midwife from various agencies:

All women who had disclosed domestic abuse were offered referral to support agencies with their consent. It was explained that referral would be made to supporting agencies if risk was high following assessment and if concerns were raised over safety or if children were involved. Sharing of relevant information to relevant agencies, referral and documentation is vital in reducing risk to this vulnerable group (Minimum standards, standard 1: confidentiality). Figure 7 highlights the agencies involved.

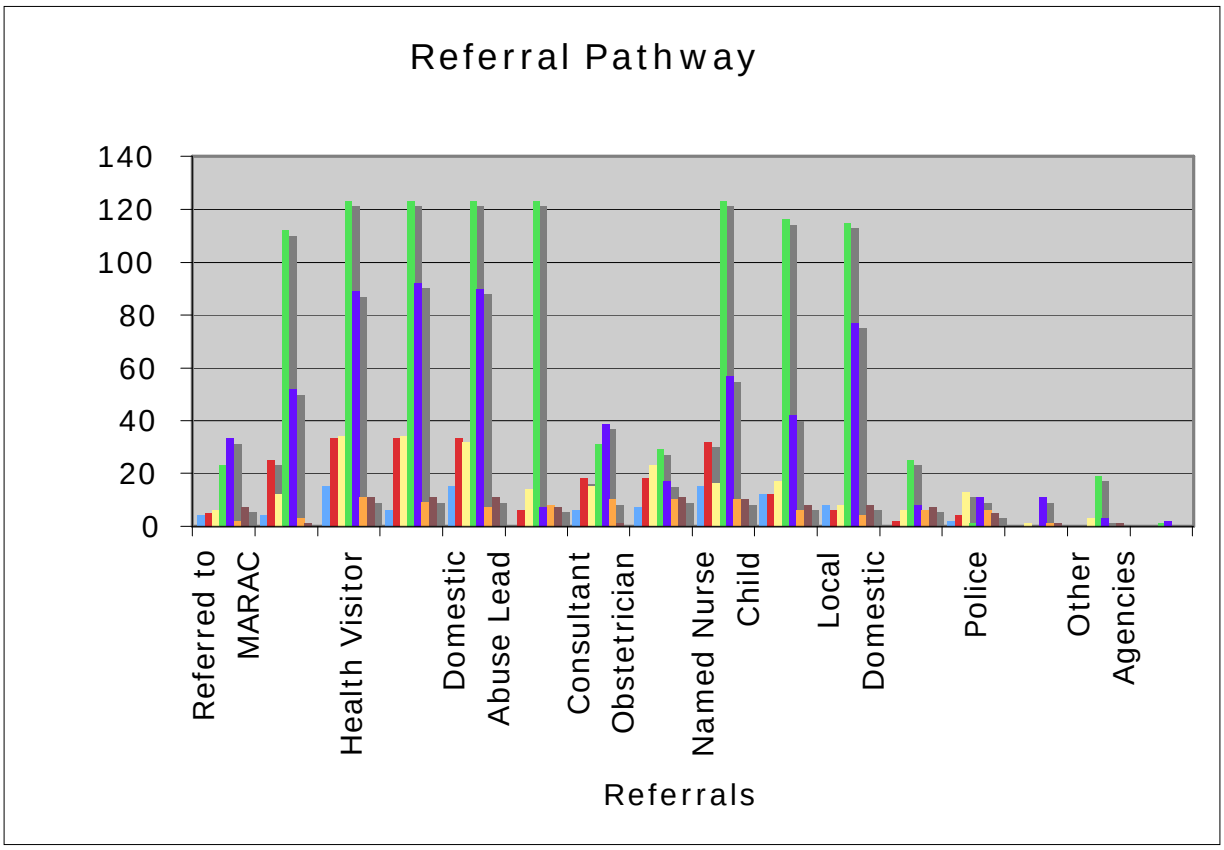
Figure 7 shows that even the Health Boards where a significant amount of data is missing or not known, midwives are part of the multi-agency team. Midwives are being informed of pregnant women experiencing domestic abuse via: Public Protection Document Form 1 (PPD1) 161 (50%) referrals from the police; The police also referred another 15 through other routes; 11 from accident and emergency

departments; 3 from TEULU; 1 Pontypridd Safety Unit; 1 from SARC: and 13 from sources unknown.

Table 10: People or Agencies referred following disclosure

Referrals to:	Number of referrals
Health Visitor	312
Midwife	310
Domestic Abuse Lead	305
Named Child Protection	256
Social Services	206
Local Domestic Abuse Agency	200
Super Midwife	159
Consultant Obstetrician	120
General practitioner	120
Women's Aid	54
Police	38
Other Agencies	7
Police Interpersonal	5
Interpretation Services	3

Figure 7: Referral Pathways



KEY Health Board	COLOUR	Health board	COLOUR
1	Light Blue	5	Dark blue
2	Red	6	Orange
3	Yellow	7	Brown
4	Green		

Age

The age group 21-30 experienced higher level in response to each question on: injury 27 (52%); feeling frightened 40 (56%); conflict over a child 33 (62%); abuse getting worse 30 (56%); use of weapons 13 (59%); threat to be killed 30 (70%); strangulation/choking 24 (60%); partner with a criminal history 64 (58%).

Health Boards

Due to the lack of information from the Health Board 4 the following analysis may be skewed. However, this may give an indication for further work in these areas. It was

found that women were significantly more likely to be injured in Health Board 5 (38.1%), Health Board 2 (28.1%) & Health Board 3 (17.5%) than the other Health Boards ($\bullet^2$=18.843, df=6, p=0.004). Significantly more were likely to feel isolated in Health Board 5 (45.1%) & BC (21.6%) than the other Health Boards ($\bullet^2$=17.353, df=6, p=0.008). Significantly more likely to have separated or tried to separate in the last year in Health Board 5 (50.9%) than the other Health Boards ($\bullet^2$=15.337, df=6, p=0.018). Significantly more likely to have been stalked/harassed in Health Board 5 (52.3%) & BC (25%) than the other Health Boards ($\bullet^2$=23.939, df=6, p=0.001). Significantly more likely for abuse to happen more often in Health Board 5 (35.7%) & BC (33.9%) than other Health Boards ($\bullet^2$=21.892, df=6, p=0.001). Significantly more likely for abuse to get worse in Health Board 5 (29.6%) & BC (25.9%) ($\bullet^2$=23.543, df=6, p=0.001). Significantly more likely to be choked or strangled in Health Board 5 (52.5%) than elsewhere ($\bullet^2$=13.32, df=6, p=0.038).

Phase Two - Audit

Following the audit of a random sample of 100 antenatal records within each Health Board it was found that the level of enquiry varied between Health Boards and ranged from 24% - 65% (Table 11).

Table 11: Percentage of records at Audit that demonstrated that a routine enquiry had been made in the ante-natal period and the actual number of disclosures made during the study period

Health Board	Routine enquiry	Disclosures
1.	34%	15 (0.2%)
2.	27%	33 (0.5%)
3.	63%	36 (0.7%)
4.	24%	124 (2%)
5.	65%	92 (2%)
6.	50%	11 (0.3%)
7.	40%	11 (0.9%)

First of all, 95% CIs were calculated to estimate the true number of enquiries that had been made, based upon the results from the 100 sample.
The upper and lower boundaries were each used to then calculate CIs of the true quantities of disclosures that have been made. The most extreme values from this pair of CIs are reported as being the Minimum and Maximum number of Disclosures.

Table 12: 95% confidence intervals of disclosures assuming all women were asked about domestic abuse in the antenatal period.

		95%CI			95%CI	
Health Board	Population	Min Enquiries	Max Enquiries	Sample Disclosures	minimum disclosures	maximum disclosures
1	6500	1612	2809	15	16	88
2	6187	1137	2205	33	67	235
3	4974	2668	3600	34	38	78
4	6223	978	2011	116	306	855
5	4186	2335	3108	89	107	182
6	3500	1412	2089	11	8	43
7	176	60	82	11	14	48

Phase Three

A random sample of 12 (total) women consented to be interviewed, which was below the anticipated recruitment number of 45.
Over the four- month period (January – April 2010) difficulty was experienced with recruitment. In the area of Health Board 5 in 2009, 92 women had disclosed domestic abuse but only 12 (13%) gave consent to be interviewed and all had left their abusive relationships at the time of the interview.

In phase three, a total of twelve semi-structured interviews were carried out. This included;

- Seven high risk.
- Three medium risks.
- One standard (low) risk.
- One case involved all three-risk categories.

Participants	Level of risk
1	High
2	Medium
3	High
4	High
5	Medium
6	High
7	High
8	High
9	Medium
10	Standard
11	High
12	Standard – medium - high

The interviews were conducted in the area covered by Health Board 5. Within this area a total of 829 cases were reviewed in MARAC in 2009 with 181 (22%) repeat cases and 92 were pregnant women (11%).

The venue for the interview was chosen by the client to ensure personal comfort and safety. The majority (11) consented for the interview to be conducted at their home and one was conducted in a safety unit. The most important considerations were that the participant felt relaxed and secure so that she was able to discuss her experiences. All participants were alone and all were asked if the interviews could be audio - taped, six agreed and six refused.

The interviews were conducted to elicit information whether the midwife had asked about domestic abuse, was referral offered and what were the positive and or negative

experiences that the women may have experienced as a result of contact with other agencies.

It was not possible to correlate risk assessment with interviewee as the data recorded on the risk assessment was anonymised
The following questions were asked and themes explored:

1. **Did you expect to be asked about domestic abuse in pregnancy?**

Positive aspects of routine enquiry

Participant (P) 2 commented *"Did not expect to asked by the midwife but was glad as I felt everything was out in the open and it was a new beginning"*.

P3 Remembers the midwife asking about domestic abuse and being given contact numbers *"She said she would help any way she could, which made me feel good, she said it was not my fault, I know it sounds daft but that really helped me feel strong"*.

P7 Said that she was asked twice about domestic abuse on the first occasion *"I would not say anything, I didn't want to see him locked up, not like that"*
On the second occasion when P7 was in hospital she was asked again and she said she felt safe to disclose as the relationship had now ended.

P10 remembers the midwife asking about domestic abuse and completing the risk assessment after the disclosure *"they gave me numbers to ring" "I think they should ask, they need to know if you or your baby is at risk"*

Negative aspects of routine enquiry

P1 Commented *"the midwife didn't ask any particular questions about domestic abuse, but wrote some brief notes" "I lost that baby and the midwife never contacted again, so I suppose she knew"*

P4 Did not expect to be asked about domestic abuse and the midwife did not ask on the first visit *" I felt I could not tell her, well it's not really on your mind when you go to clinic"*
"I was worried after the assault as I was worried about the baby, she did ask me this time but I didn't tell her as I thought she would think I would be a bad mother"

P 5 felt the midwife was busy when she asked and felt she was rushed *"I did not feel I could tell her and she did not ask again"*

P11 remembers that the midwife asked her about domestic abuse *"they asked me about the bruising. I didn't want them to know 'cos they would tell Social Services so I said it was only once. They referred me to Social any way"*

2. Did it offend you to be asked about domestic abuse?

All twelve participants said they were not offended to be asked about domestic abuse, each felt it was the role of the midwife to ask.

P4 commented, *"I didn't mind her asking but I didn't want her to know"*

P8 felt the midwife should have a bigger role. *"I was asked on my other two and my sister was asked"*

P9 commented that midwives did not ask her about domestic abuse, but asked if she would of disclosed, P9 commented,
"I might of disclosed, I think I would of, I am a nervous person, I suffer from depression, I am on anti depressants, I would want them to know. I would not of been offended"

P10 felt strongly that it was the midwives role
"I would tell them everything because they have a right to know, I would not of been offended. I got all the help I could get, I couldn't of done it on my own"

P12 *"I was not offended but I said everything was ok because when I was pregnant it was. We argued but he only started to hit me after the baby was born"*

3. **What made you decide to disclose on this occasion?**

P2 *"I was pregnant and he had left. If I was still in a relationship with him I would not of asked for help or told anyone. I would have been too frightened you just get on with it"*

P6 Said that pregnancy was the reason for disclosing domestic abuse when the midwife asked and gave a detailed account of a violent assault from her ex boyfriend. Asking her reason for disclosing on this occasion she commented:
"I got the baby to think of"
"Putting my baby first"
"I wanted to tell the midwife and I knew if I didn't, my mum would of told them"

P8 did not disclose domestic abuse when asked by her midwife. However she decided to disclose when the relationship broke down *"he pushed and shoved me and tried to drown me, it was more mental with him"*
P8 stayed in hospital for four days as she was so afraid *"Just in case he came and found me"*

4. **Who were you referred to?**

The twelve participants were able to recall a variety of agencies including;

a. Police
b. MARAC
c. Court
d. Witness support
e. Health, midwife, health visitor, A&E, GP
f. Housing
g. Social Services
h. Safer Merthyr Tydfil
i. Domestic abuse resource team

j. Independent domestic violence advocate
k. Women's Aid (Services)

5. Which agencies were helpful?

P1 was referred to a local domestic abuse safety unit which she found very supportive, she was also aware that her case had been heard at MARAC. As a result, she now has alarms and target hardening fitted to her house.

P2 *"Midwife was supportive and seemed to know what help was out there. You feel so ashamed to ask yourself, it takes such an effort you just think it will get better"*

P8 commented that local services *"I had assessment and within 24 hours they had put alarms, locks on doors and windows, markers on the house"*.

6. Which agencies were not so helpful?

Health - P1 commented that the midwife was very supportive, but on one occasion discussed a past abusive relationship in the presence of the new partner. At the time, she did not see this as a problem but later she felt this was used against her as her current partner said he would *"be more violent"*.

A few days later P1 experienced domestic violence and was seen in hospital

"If you say you've been assaulted there should be something in place, not too harsh because you would be too afraid to say anything but they could offer you something without making you have it. It would be useful if they gave you one number. Leaflets are not helpful, health give you leaflets for everything rather than talk to you"

P2 – Police were not helpful *"They called out* (to the house) *to an incident and told us both to grow up!"*

"Social Services were not helpful they didn't get back after I phoned with a query and said I had to stop contact or the children would be put on the child protection register" "Housing not helpful until he was removed off (housing) *list"*.

P9 found housing unhelpful *"housing not helpful I waited over two years for re housing and I got my own place then"*

P11 found the same *"When I moved from my mother's house I was moved back to the area I had moved from and put opposite his family"*

7. Are there areas, which could be changed or areas that professionals could do differently?

P1 felt *"generally there should be more done to raise awareness about domestic abuse, more media coverage. Neighbours knew but did not want to be involved. It would be helpful if they could phone the police"*

8. Is there anything you would like to add?

This question was emotively summarised by P9 who discussed how different she found this pregnancy compared to her pregnancy eight years ago, she said *"I seem to have violent relationships, I don't know why they just seem to pick on me"*

"Eight years ago I wished I had been asked. I lost a baby girl because he was punching me full force in the stomach"

"So I lost her when I was 6 months pregnant. It (domestic abuse) actually started when I was pregnant, I had no support I stayed with my mum."

"He's still violent now from what I have been told, he's violent to his wife. A leopard never changes his spots."

Their relationship ended when P9 lost the baby *"we went to the funeral together but that's all we spilt then"*

When asked if any health professional asked her about domestic abuse she replied *"No it was one of those things that happened then, in the house. No one took any notice"*

"I had to go to counselling but there was nothing else around, you didn't think about it you just got on with it"

"When I look back to then with what support I have now it's amazing, everyone has been so supportive".

Phase Four - Focus group

A focus group was held as part of the regional meeting which had four midwives and three health visitors in attendance. The group was facilitated by LL as the chair of the group and notes were taken by a colleague to ensure correct understanding was achieved by the group. As natural a discussion as possible was encouraged to explore the impact and support those present felt they required, following the implementation of the Domestic Abuse pathway.

Five key areas emerged:

1. Identified lead

All midwives and health visitors acknowledged the importance of domestic abuse within their work and each Health Board in Wales now has an identified midwife (usually the child protection midwife) to take forward training and audit collection.

2. Referral

All midwives felt there was a greater understanding and involvement with the community support agencies, especially the local domestic abuse co-ordinators who in all areas were assisting with the training programmes.

It varied across Wales as to who sat on the Multi-Agency Risk Assessment Conference (MARAC). In some areas it is the midwife, in others it is the senior nurse for child protection, but most importantly the group felt that health professionals were now involved and information was being fed back to the midwives; they felt part of a multi-agency team which previously they had not.

3. Training

Domestic abuse training was now included on midwifery public health training days but was delivered in a much shorter time (1-2 hours) than the training tool was designed for (1 day). All commented that training had increased across maternity units but a full day was viewed as a "luxury" and therefore they needed to deliver it in a shorter time. In some Health Boards, domestic abuse was included on 'Induction'

and staff training days. It is now on the agenda within higher education, with one university developing a multi-agency domestic abuse modules. Universities in Wales have now included domestic abuse awareness and training on pre and post registration courses.

4. Impact

All felt that domestic abuse awareness was now much higher and the pathway has helped with guidance, especially around referral, although concerns were raised over information sharing if the woman refused consent. Dealing with a disclosure was time consuming but the links and referral to support agencies has helped with this and there is improved communication and information sharing between agencies. It was highlighted that not all Health Boards had Information Sharing policies although all had domestic abuse policies.

5. Support

Midwives felt involved and part of a multi-agency team, which they had not felt before. Health visitors historically had greater involvement with community multi-agency teams but now midwives felt this inclusion also. This was highlighted with an invitation by the police for health professionals to take part in free multi-agency DASH training in October 2009. The domestic abuse leads in each of the Health Boards have given support and guidance to midwives working clinically.

Discussion

There was variation found at audit between 24% -65% of women being routinely asked about domestic abuse in the antenatal period in Health Boards in Wales. This differs from the stated minimum standards developed by the All Wales Midwifery and Health Visiting Networking group (Appendix 2). Standard Two states that 100% of women should be asked at least once about domestic abuse during their pregnancy. The results demonstrate that no Health Board in Wales achieved this standard in 2009. Audit can be used as a positive tool with feedback to the Health Board and to midwives on their performance. It has been shown that using audit and individual performance feedback on screening for domestic abuse can increase enquiry from 60% to 91% over a short period of time (Duncan et al, 2006). It may be considered

that if Standard Two is not being met by midwives should it therefore be an issue to be addressed within their annual individual performance review so that any required need including training can be actioned.

There have been many studies investigating why health care professionals, including midwives, do not ask about domestic abuse. The most common of these factors are: lack of time, lack of training, inadequate resources and feeling uncomfortable asking (Buck and Collins, 2007). However, as demonstrated in a study in Scotland, 19% of midwives disclosed that they had been in an abusive relationship and that there was a need for the provision of a support system for themselves and for their abused colleagues (Barnett 2005). In South Africa, 39% of nurses surveyed had personal experience of domestic violence (Christofides and Silo (2005). This did not impact on their care provision. It was observed that if nurses had cared for friends or family suffering from domestic violence then this raised the quality of their provision of care for patients presenting following a domestic incident. If the outcome is improved then the more nurses can identify and intervene with domestic violence the better. Also, systems need to be developed in practice to support midwives in this aspect of their role, as postulated by Mollart et al (2009), the benefits of clinical supervision in addition to education and training to share experiences.

Of the women that were asked, 322 disclosed, however, if Standard Two had been achieved across Wales potential the number of women disclosing may have been significantly higher (see table 12), 1,829 as suggested. Nevertheless, women who were interviewed in Phase three of the study, particularly those at high risk, stated that they would not have disclosed if they were still with their partner. It is known that women fear the abuser's reaction to disclosure, consequences for their children, shame, deny that the abuse is happening and the judgmental reactions of those to whom they disclose (McCauley et al 1998). It is also known that a perpetrator will accompany their partner to their antenatal appointment to act as a deterrent to the women being asked about abuse and/or informing the health care professional abuse occurring (Mezey 1997). Consequently, although the reported levels of disclosures varied between 0.2% and 6.25% the true prevalence of domestic abuse in Wales is still not known but we have a greater knowledge of associated risk factors. Also Health Board 1that reported the least proportion of disclosures (0.2%) to births had

the highest homicide rate needs to be reviewed. It needs to be considered that the women interviewed commented that they felt it was a midwives role to ask and all twelve said they were not offended if the enquiry was in a safe environment and they were alone. Four women (33.3%) said that being pregnant was their main reason for disclosing.

Some elements of Standard Three were also not met, especially that all staff complete the All Wales Pathway in order to highlight the severity of risk. As 113 women who had disclosed as the Health Board 4 did not have a completed pathway, 108 cases disclosures were made to the police completing a PPD1 form, and 5 in the A&E department and then referred onto the midwife. So a risk assessment was not completed by the midwife. However, it was known that these women had been referred to other professionals and agencies. There were 256 (80%) referred to a named child protection individual in line with Standard Three and Standard Six if they were concerned about the welfare of a child.

Therefore, it may be considered that the Health Boards have not met the requirements of Standard Four to 'ensure their staffs are clear regarding the documentation process'. It appears from the findings that it is the police and A&E staff who are creating links, gathering and sharing information and referring onto the midwife. This communication is important as the risk factors being collected are risk factors associated with the future potential for murder of the woman or severe harm. In the fifth report of the Confidential Enquires into Maternal Deaths (RCOG 2004), of the 378 women who had died as a result of domestic abuse none had been routinely asked about abuse. Nonetheless, 45 had disclosed voluntarily that they were being abused. It was acknowledged in the report that there was a need for screening and midwives were in an ideal position to conduct this. Also McDonnell and colleagues (2006) found out that 99% of women attending for an antenatal appointment thought that screening for domestic abuse was acceptable and necessary.

Consequently, leadership and support are important issues that need to be addressed and, as commented by representative members of regional groups, essential to the continued success of the pathway and training. Professional concerns were raised over the inconsistency of domestic abuse leads in maternity units with regard to collecting

data, training and membership to MARAC. In Health Boards where midwives attend the MARAC information sharing and multi-agency working are in much more evidence. However, this does not happen in all the Health Boards. It is known that the midwifery lead who also has the role as lead for child protection in one health Board does not attend a MARAC or receive information from the police resulting in a severe gap in knowledge and a detrimental impact to those families at risk. As it is known that 60% of the cases heard at a MARAC results in a cessation of abuse (CAADA 2010). Nonetheless in 2009, of 373 referrals made to Social Services 91 (24%) cited domestic abuse as the main reason for referral.

There appears to be a change in attitudes by the police who have become more responsive to the needs of those who suffer from domestic violence (Akers and Kaukinen 2009). Under new legislation in the UK, there is a stated requirement that all justice agencies should provide support, protection, information and advice to victims (Hoyle 2008). The Domestic Violence, Crime and Victims Act (2004) also makes common assault an arrestable offence. Consequently the police can arrest a perpetrator for a minor assault that may not have caused an injury. Although there was found to be significant associations between the partner being in trouble with the police or having a criminal history and the risk to the victim of: injury, being frightened, isolation, separation, conflict over a child, harassment, controlling behaviour, attempted strangulation, hurting someone else, financial issues, and problems with misuse of substance or mental health issues. It is not known from the information available the reason for the criminal history of the perpetrator and whether it is related only to domestic violence to other crimes but it warrants further investigation. This is also necessary for the perpetrators who had broken bail. Under Standard Four is the provision of interpreters, 3 women (1%) were referred to interpretation services. As has been reported, one of the issues raised for being afraid was the fear of deportation. Uncertain immigration status can be used to evoke fear and shame (Pinn and Chunko, 1997) which is acknowledged as a stressful process that can cause isolation and reduced economic circumstances which combined could trigger domestic abuse (Sorenson, 1996). Although only 3 used interpretation services, it is known that 4% of the Welsh population in the 2001 census declared themselves to be other than white British (ONS 2004). It has been proposed that

screening ethnic minority groups for domestic abuse may be considered racism (Cross-Sudworth, 2009) but screening all women is working towards equality for all.

Standard Five requires that all agencies use the same tool to assess risk and the same threshold to refer to a MARAC. This requires all agencies including midwives to refer to MARAC victims with a risk score of 14 or above, or if in their professional judgement there is a need for referral. This was not met by the Health Board 4 where 33 (64%) victims were considered at high or very high risk not being referred to a MARAC. Also there were 34 (27%) victims where there was no indication of their level of risk.

It may also be considered that 145 had stated that they not sustained an injury but, of these, 24 had experienced a life threatening event through attempted strangulation, suffocation or drowning. Indeed, 16 (67%) of those who had gone through this experience did not consider it as a threat to kill by their partner. Even though no injury was sustained, 10 had been sexually abused. These findings also highlight some of the problems of documentation of the level of risk and implications for safety planning.

This study has shown that 92 (29%) had a partner who misused substances or had a mental health problem. This was not found to be significantly associated with the risk of injury to the victim. Nonetheless it is not known how many of the victims were abusing substances themselves. Stewart and Cecutti (1993) reported that abused pregnant women were more likely to be using prescription and non prescription drugs than those not abused during their pregnancy. Therefore in order to get a balanced picture, the profile of the abused and the abuser may need to be reviewed.

Garcia-Moreno (2002) suggests that there is no evidence that screening has any long term benefit to women and therefore there is a need to look at long term death rates together with quality of life of the women who disclose. However, there is an issue with victims minimising the risk in their response to disclosure during risk assessment and the lack of willingness to discuss after disclosure. In Health Board 5, 92 women had disclosed domestic abuse. Of those only 12 consented to be interviewed and all had left their abusive relationships at the time of the interview. The majority of cases

were high risk (61.5%), but it is sometimes too simplistic to discuss risk categories since women talked of the abuse starting with one category (physical, emotional, sexual) and escalated over time or even in during one episode. As discussed by Participant 12 her abusive relationship started as verbal abuse and escalating over a period of one and half years to physical assault and threats which continued after the relationship had ended.

Victims also have to take responsibility to minimise future risk, by taking seriously any recommendations given to ensure their future safety (Hoyle 2008).

Conclusion

In Wales, domestic abuse is now being addressed by a multi-agency workforce. Midwives are in a key position to assess risk and refer to appropriate agencies since pregnancy is a known trigger factor for the start and intensification of domestic abuse places. Although training for this element of their role in completing the domestic abuse pathway has been given to midwives in all Health Boards across Wales none of the Health Boards are meeting the minimum standards required for routine enquiry for risk assessment for domestic abuse. In addition, all women are not being asked about abuse moreover those who have been identified by other agencies as being abused are still not being assessed for risk by midwives, since there were seven homicides due to domestic violence. Consequently, there is a need for leadership within Health Boards to ensure that the care pathway is implemented together with support and training for all healthcare professionals and that there is improved communication between agencies, especially within MARAC. Finally, there is a need for improved communication skills so that victims or potential victims are able to feel capable to disclose abuse within their relationship.

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APPENDICES

1. **All Wales Domestic abuse pathway.**

2. **Domestic abuse minimum standards.**

3. **Staff Protocol.**

4. **Interview Schedule.**

Hosp No		**NHS No**		
Surname			**Miss / Ms/ / Mrs**	
Forename				
Address				
Post Code			**D.O.B**	**E.D.D**

All Wales Domestic Abuse Pathway

DA2 - Pathway to be completed when there is a disclosure of abuse

Safe Contact Number:-	*Safe time to call:-*
Perpetrator's name:- *D.O.B:-*	*Perpetrator's Address:-* *D.O.B:-*

Names & Ages of Children:	
Please state whether living at home	
Name of School/s	

SIGNATURE SHEET - RECORD ALL ENTRIES IN *BLACK INK*

Health Professional	**Signature**	**Profession / Base**	**Contact No**

Safety Numbers:

All Wales Domestic Abuse	**08088 010800**
Samaritans	**08457 909090**
Black Association of Women Step Out	**02920 343 154**
Teulu Partnership Team (Merthyr Tydfil)	**01685 388444**
Pontypridd Safety Unit (RCT)	**01443 494194**

Name **Date:**
Date of Birth **Time:**

Restricted when completed

CAADA - DASH Risk Identification Checklist for use by Independent Domestic Violence Advisors (IDVA) and other non-police agencies' for MARAC case identification when domestic abuse, 'honour' – based violence and / or stalking are disclosed.

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present þ. Please use the comment box at the end of the form to expand on any answer It is assumed that your main source of information is the victim. If this is not the case please indicate in the right hand column. **<u>Please note questions in BOLD indicate higher risk.</u>**	**Yes (tick)**	**No**	**Don't know**	**State source of info if not the victim e.g. police officer**
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury)	£	£	£	
2. Are you very frightened? **Comment:**	£	£	£	
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, including children) Comment:	£	£	£	
4. Do you feel isolated from family / friends i.e does (name of abuser(s)…..) try to stop you from seeing friends / family / doctor or others? **Comment:**	£	£	£	
5. Are you feeling depressed or having suicidal thoughts?	£	£	£	
6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?	£	£	£	
7. Is there conflict over child contact?	£	£	£	

Source: CAADA MARAC Implementation Guide – Version 5 September 08

Name: **Date:**

Date of Birth: **Time:**

Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer	**Yes (Tick)**	**No**	**Don't Know**	**State source of info if not the victim e.g. police officer**
8. Does (…..) constantly text, call, contact. Follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done).	£	£	£	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	£	£	£	
10. Is the abuse happening more often?	£	£	£	
11. Is the abuse getting worse?	£	£	£	
12. 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 (HBV) and specify behaviour).	£	£	£	
13. Has (…..) ever used weapons or objects to hurt you?	£	£	£	
14. Has (…..) ever threatened to kill you or someone else and you believed them? (if yes, tick who). You Children £ Other (please specify) £	£	£	£	
15. Has (…..) ever attempted to strangle/choke/ suffocate/drown you?	£	£	£	
16. Does (…..) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (if someone else, specify who).	£	£	£	
17. Is there any other person who has threatened you or who you are afraid of? (if yes, please specify who and why. Consider extended family if HBV).	£	£	£	
18. Do you know if (…..) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV). Children £ Another family member £ Someone from a previous relationship £ Other (please specify) £	£	£	£	

Source: CAADA MARAC Implementation Guide – September 08

Name: **Date:**

Date of Birth: **Time:**

Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer	**Yes (Tick)**	**No**	**Don't Know**	**State source of info if not the victim e.g. police officer**
19. Has (…..) ever mistreated an animal or the family pet?	£	£	£	
20. Are there any financial issues? For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues?	£	£	£	
21. Has (…..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known) **Drugs £ Alcohol £ Mental Health £**	£	£	£	
22. Has (…..) ever threatened or attempted suicide?	£	£	£	
23. Has (…..) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant). Bail conditions £ Non Molestation/Occupation Order £ Child Contact arrangements £ Forced marriage Protection Order £ Other £	£	£	£	
24. Do you know if (…..) has ever been in trouble with the police or has a criminal history? (If yes, please specify). DV £ Sexual violence £ Other violence £ Other £	£	£	£	
Total yes responses				

MARAC THRESHHOLD = 14 ticks or more in the yes box - (Please consider local variations)

<u>Please note questions in BOLD indicate higher risk and MARAC referral may be made with fewer ticks if it includes the high risk questions, please seek advice.</u>

In all cases take victims perception of their risk very seriously and use professional judgement if a client appears to be high or very high risk even if they do not meet the criteria outlined above.

Consider victims situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, honour based systems and minimisation. Are they willing to engage with your service? Consider abusers occupation/interest – could this give them unique access to weapons.

MARAC REFERRAL FORM

Restricted when completed

Lead agency: Tel: Fax:

Date:

Victim's Name:

Date of birth: Telephone Number:

Address of victim:

Perpetrator name:

Date of birth:

Address of perpetrator:

Children's names: date of birth:

Address of Children:

Number of ticks on checklist:

Reasons for referral:

Background and risk issues:

Why does this case require a multi agency approach?

Is the person referred aware of the MARAC referral?

Attach completed risk assessment with the MARAC Referral keep copy for your records
Pages 1 - 5

Referring agency:

Contact details and Telephone:
Mobile:
Email Address:

Name:
Date:

Date of Birth:

Restricted when completed

Practitioners Notes

Source: CAADA MARAC Implementation Guide – September 08

DA2 REFERRAL PATHWAY

Please document details of professionals within the multi-disciplinary team informed *NB Ask for consent to share information with other agencies* - (Refer to Minimum Standards / All Wales Child Protection Procedures / Framework for the Assessment of Children in Need for Guidance) See page 8 Legal Grounds when considering information sharing without consent.

Name: **Date:**

Date of Birth:

Profession	**Name**	**Date**	**Time**	**Base and Tel no / comments**
Health Visitor				
Named Midwife				
Domestic Abuse lead for Trust (include on database or photocopy)				
Supervisor of Midwives				
Consultant Obstetrician				
GP				
Named Nurse/ Midwife Child Protection				
Social Services - Duty Officer				
Named Social Worker				
Local Domestic Abuse Group IDVA (Independent Domestic Violence Advisor) Domestic Abuse Co-ordinator				
Women's Aid				
Police				
Police – Interpersonal Violence Unit				
Other Agencies				
Interpreter – NB This must not be a family member				
Referral to MARAC				

Date	Name of Professional	Signature	Status	Location of Enquiry	Weeks Gestation	Outcome

Legal Grounds When Considering Sharing Information Without Consent

Protection Against Disclosure

LEGAL ISSUES	SOURCE
Protection of personal data	Data Protection Act 1998
Duty of confidentiality	Common law
Right to private and family life	Human Rights Act, Article 8

Main Lawful Grounds for Sharing Without Consent

PURPOSE	LEGAL AUTHORITY
Prevention and detection of crime	Crime and Disorder Act 1998
Prevention and detection of crime and/or the apprehension or prosecution of offenders	Section 29, Data Protection Act (DPA)
To protect vital interests of the data subject; serious harm or matter of life or death	Schedule 2 & 3, DPA
For the administration of justice (usually bringing perpetrators to justice)	Schedule 2 & 3, DPA
For the exercise of functions conferred on any person by or under any enactment (police/social services)	Schedule 2 & 3, DPA
In accordance with a court order	
Overriding public interest	Common Law
Child protection – disclosure to social services or the police for the exercise of functions under the Children Act, where the public interest in safeguarding the child's welfare overrides the need to keep the information confidential	Schedule 2 & 3, DPA
Right to life Right to be free from torture or inhuman or degrading treatment	Human Rights Act, Articles 2 & 3

Source: CAADA MARAC Implementation Guide – September 08

Name:

Date of Birth:

DATE	ACTION PLAN	SIGNATURE

Please use this page to record a 'diary' of events / whether support referral agencies have responded and are actively involved.

EVIDENCE BASED MINIMUM STANDARDS (All Wales midwifery & health visitors networking group)

STANDARD ONE - CONFIDENTIALITY

STANDARD	PRACTICE GUIDELIENS	EVIDENCE BASE	RESOURCE REQUIRED
Professionals need to be aware of the need for confidentiality – and its limitations	• All health professionals recognise the duty to respect the woman's confidentiality but must be aware of its limitations in the wider public interest • The law recognises significant exceptions to the duty of confidentiality If a woman withholds consent, or if consent cannot be obtained disclosures may be made where: • They can be justified in the public interest • They are required by law or by order of a court • Where there are potential child protection issues – there is a need to act in accordance with national and local policies • The professional is justified and has a duty to share information with social services, police or other agencies where there is an increased risk of abuse / child protection concerns Extreme care should be taken to protect the safety of victims of abuse. Information should not be disclosed to any third party who may breach their safety.	• NMC (2002) Code of Professional Conduct • ACPC (2002) All Wales Child Protection Procedures • Data Protection Act 1998 • Human Rights Act 1998 • Robinson A (2004) www.cf.ac.uk/socsi/whoswho/robinson.html • Home Office (2004) Safety and Justice: Sharing Personal Information in the Context of Domestic Violence – an Overview Home Office Development and Practice Report Communication Development Unit, Home Office, London, England www.homeoffice.gov.uk/rds • WAG (2000) Working Together to Safeguard Children • WAG (2001) Framework for the Assessment of Children in Need and Their Families www.wales.gov.uk/childrenfirst	• Time • A safe, quiet environment • Support and supervision for staff • Staff Educational Training

STANDARD TWO – ROUTINE ENQUIRY

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
All Women will be routinely asked about domestic abuse in the antenatal period	• Women should be alone when asked about domestic abuse • Information cards to be given to women when beginning routine Enquiry • Ensure lone contact with the woman at least once in pregnancy • If unable to see the woman alone, highlight this as a priority for follow up and seek advice accordingly • Routine enquiry should not be a one off event. It should be at opportunistic intervals throughout the pregnancy • Ensure the provision of a safe, supportive environment • Ensure effective communication takes place between midwife / health visitor e.g. 'handover' exchange of information	• RCOG (2004) Confidential Enquires into Maternal Deaths – why Mothers Die 2000 – 2002 • RCOG Press, London, England • (NICE 2003) Antenatal care – Clinical Guideline 6 • DOH (2004) National Service Framework for children Standard 11 – Maternity Services • WAG (2001) Domestic violence: A Resource Manual for Health Care Professionals in Wales • Mann C (2003) Domestic Violence Good Practice Guidelines – Mansfield Care Trust	• All Wales Information cards • Education & Training • Safe and private environment • Time • Access to appropriate interpreters

STANDARD THREE – DISCLOSURE

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
Women who disclose will be given appropriate support and information. They will be offered referral to appropriate agencies	• Provide time for the woman • Validate that what she is disclosing is wrong and reinforce that the abuse is not her fault • All staff to complete the All Wales Pathway in order to highlight the severity of risk and make appropriate referrals to support agencies • Respect her need for confidentiality, but staff **must** adhere to ACPC Procedures. • Give accurate up to date information of relevant agencies • If you are concerned about the welfare of a child / children then refer to Child Protection Nurse / Midwife in accordance with All Wales Child Protection Procedures / Local Guidelines *Consent is not essential where there ar potential child protection concerns / imminent threats to her safety* • Provide an interpreter **N.B. This must not be a family member**	• Trusts guidelines / polices consent • Trust policies on confidentiality • Date Protection Act (1998) • WAG (2001) Domestic Violence: A Resource Manual for Health Care Professionals in Wales • ACPC (2002) Framework for the Assessment of Children in Need and Their Families www.wales.gov.uk/childrenfirst • Home Office (2004) Safety and Justice: Sharing Personal Information in the Context of Domestic Violence – An overview Home Office Development and Practice Report Communication Development Unit, Home Office, London, England www.homeoffice.gov.uk/rds • NMC (2002) Code of Professional Conduct	• Interpreters • Provision of a quiet environment • Time • All Wales Pathway • Appropriate contact numbers for support agencies

STANDARD FOUR – DOCUMENTATION

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
All information disclosed will be recorded clearly stating:- • Date • Time • Persons present	• LHB's / Trusts will ensure their staff are clear regarding the documentation process • Record events using the woman's own words • Document whether children were present at the time f the abuse • Liaise with A&E Staff/Police as the following may be required:- *Provide a diagram of the body with a written description of any injuries* *Clothing may be saved for the police investigation* *Polaroid photographs may be taken and regarded as evidence* • Arrange interpreter:- o Same gender o Language o Sign o Advocate for learning disabilities	• WAG (2001) Domestic Violence: A Resource Manual for Health • Local Trust Policies – consent and confidentiality • NMC (2002) Code of Conduct • WHO (1997) Violence against women information pack • Home Office (2004) Safety and Justice: Sharing Personal Information in the Context of Domestic Violence – An Overview Home Office Development and Practice Report Communication Development Unit, Home Office, London, England www.homeoffice.gov.uk/rds	• Training • Time • Clinical supervision • Camera equipment • Suitable room for examination and investigation • Interpreter • Data collection – Consider use of All Wales Pathway for Routine enquiry

STANDARD FIVE – RISK ASSESSMENT

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
Undertake a risk assessment for the woman, unborn baby, or any other children in the household. A risk assessment to ensure staff safety should also be completed	• The practitioner should be familiar with the Domestic Abuse Resource Manual for health care Professionals in Wales • Assess level of risk using the All Wales pathway for Routine Enquiry (T*his system is intended a as guide only and reflects a particular moment in time. Please remember that the situation may change quickly).* *Consider not only the high risk situation but also any strange or unusual behaviour reported by the woman.* **NB. Scores 7 or above must be referred to the MARAC system (or its equivalent) as this indicate a VERY HIGH risk situation**	• LHB / Local Trust Lone Worker Policy • Robinson A (2004) www.cf.ac.uk/whoswhos.robinson .html • South Wales Police Public Protection Unit – FSU 9 • Trust Health and Safety Policy • Trust Violence and Aggression Policy • South Wales Adult Protection Forum (2002) **Protection of Vulnerable Adults – Implementing the Safe Hands Guidelines for the Protection of Vulnerable adults in Wales. Inter Agency Policy and Procedures for Responding to Alleged Abuse and Inappropriate Care of Vulnerable Adults in South Wales** www.npt.gov.uk • WAG (2001) Domestic Violence: a Resource Manual for Health Care Professionals in Wales	• Time • Training • Privacy / Safe Environment • All Wales Pathway for Routine Enquiry

MARAC = Multi Agency Risk Assessment Conference

STANDARD SIX – CHILD PROTECTION

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
Where actual or the likelihood of significant harm is identified, a referral under the Child Protection Procedures must be made The welfare of any child is paramount including the unborn child Consider also the implications fro the pregnant teenager < 18 yrs	• Establish whether children are present within the home when abuse is taking place. • Assess level of ganger • Consider other situations which may impact in the health and wellbeing of the child and take appropriate action • Named Nurse or Midwife for Child Protection must be informed of any concerns for the welfare of a child • Involve Multi Agency Partnerships • Seek guidance and support from Education / Education welfare Officers where the 'child' herself may be pregnant. Ask the woman for her (verbal) consent for referral to other agencies • If you are concerned about the welfare of a child . children then seek guidance from . refer to Child Protection Nurse / Midwife / Specialist in accordance with All Wales Child Protection Procedures / Local Guidelines / Framework for Assessment of children in Need and Their Families *Consent is not essential where there are potential child protection concerns / imminent threats to her safety*	• All Wales Child protection Procedures (2002) • WAG (2001) Framework for the Assessment of Children in Need and their Families www.wales.gove.uk/childrenfirst • WAG (2001) Working Together to Safeguard Children • Hughes H (1992) Impact of Spouse Abuse on Children of Battered Women Abuse Update • NCH (1994) Action for Children the Hidden Victims:- Children and Domestic abuse, NCH Action for Children London, England Reynolds J ed (2001) • Not In Front Of The Children One Plus One, London, England • DOH (2003) What to Do If You're Worried A Child is Being Abused, Department of health Publications, London, England www.doh.gov.uk/safeguardingchildren	• All Wales Child Protection Procedures (2002) • Trust Child protection Procedures, named Nurse / Midwife • Clinical Supervision • Education and Training • Links with advocacy services for children • Links with Education / Education Welfare Officers

STANDARD SEVEN – SAFETY PLANNING FOR STAFF AND VICTIM

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
To ensure women are equipped with accurate and appropriate advice to stay safe To ensure health professionals are not placed in situations of threat or ganger	Process of safety planning. Support the woman:- • Build a trusting, non judgemental relationship • Encourage the woman to assess her safety needs • Review current risk – to he own life an to her children • Offer appropriate, accurate information regarding support agencies • Be an advocate for the woman with other agencies (with consent) • Undertake a risk assessment of your environment e.g. when visiting a woman in her home – consider – geographical location, can you get out safely. **N.B. ensure that you do not place yourself or your colleague at risk in a potentially violent situation when supporting someone else**	• Welsh assembly Government (2001) Domestic Violence Resource Manual for Health Care Professionals • Home Office (1999) Domestic Violence – Break the Chain. Multi Agency Guidance for Addressing Domestic Violence • LHB / Trust Lone Worker Policy • All Wales Information Card	• Time • Suitable room • Counselling service • Training and education • Access to appropriate agencies • All Wales Pathway for Routine Enquiry • Trust Policy for staff experiencing Domestic Abuse • Safety policies as per Trust:- o Mobile phones o Rape alarms o Room alarms o Lone Worker Policies o Violence and Aggression Training

STANDARD EIGHT – PROVISION OF INFORMATION & REFERRAL

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
Provide woman with accurate information i.e Resources, help and agencies available . Ensure multi-agency working	• Adopt a calm, open approach • Give All Wales Information Card • Give information that is non judgemental and accurate. Be courteous and empathetic to her needs • Provide written information should the woman want it • Display information within the Trust • Ensure information (especially telephone numbers) are current, if not this could endanger the woman	• Protection from Harassment Act (1997) • Domestic Violence, Crime and Victims Bill (2004) • Perinatal Institute (2004) Perinatal Review – Domestic Violence Detection / Important Agencies www.perinatal.org.uk • Criminal Justice Act (1998) • Offences against the Person act (1861) (ABH, GBH) • Police and Criminal evidence Act (1984) • Public Order Act (1986) • Criminal Justice and Public Order (1994)	• Time • Training • Display boards • Literature – information and description of other agencies roles • Information in a range of different languages • Information as to where to seek help for the perpetrator as well as the victim • Access to Women's Aid / DAUs, Family Support Units, etc • Posters – Contact information may include telephone numbers of local agencies e.g. Legal services – consider those who specialise in Domestic abuse Hotlines / Helpline numbers

STANDARD NINE – SUPPORT & SUPERVISION OF STAFF

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
To provide adequate support to staff who are dealing with domestic abuse issues	• Safety and disclosure of information should be discussed with line manager . named nurse for child protection • Access to clinical supervision / midwifery supervision to be provided in order to allow staff to debrief, seek further advice from line manager or other relevant personnel • Explore own issues which may influence practice and seek advice accordingly • Adherence to minimum standards and principles • Develop skills and identify training needs • Consider advice and support from local domestic abuse units	• Mann C (2003) Domestic Violence Good Practice Guidelines – Mansfield District and Ashfield Primary Care Trust • Local Domestic Abuse Guidelines for Staff • NMC (2004) Midwives Rules and Standards	• Human Resource Policies • Education and Training • Staff Counselling Service via Local Occupational Health Departments •

STANDARD 10 – EDUCATION AND TRAINING

STANDARD	PRACTICE GUIDELINES	EVIDENCE BASE	RESOURCE REQUIRED
Staff will be confident and competent to deal with issues involving domestic abuse Staff should be aware of basic legislation to help and reassure the woman	• Awareness of physical and general indicators • Midwives and Health Visitors to use routine enquiry as part of antenatal care • All Trusts / LHB's to adopt the All Wales Pathway for Domestic Abuse as Good Practice	• Mann C (2003) Domestic Violence Good Practice Guidelines – Mansfield district and Ashfield Primary Care Trust • Zachary et al (2002) Multifacted System of care to improve recognition and management of pregnant women experiencing domestic violence (Women's health Issues Vol 12, No 1 Jan / Feb p5 – 15) • (NICE 2003) Antenatal care – Clinical Guideline 6 • (WAG 2001) Domestic Violence: A Resource Manual for Healthcare Professionals in Wales • Home Office (2004) Safety and Justice: sharing Personal Information in the Context of Domestic Violence – An Overview Home Office Development and Practice Report Communication Development Unit, Home Office, London, England www.homeoffice.gov.uk/rds	• Induction days for new staff to include awareness on issues relating to domestic abuse • Mandatory in-service training days for all health professionals • Study leave for staff in order to attend training sessions • Inclusion of Domestic Abuse on pre and post registration education curriculum.

Staff Protocol

Antenatal Domestic Abuse Disclosure
RE2 data base.

Data base will be emailed to the midwifery domestic abuse leads to collect information following a domestic abuse disclosure.

Please follow the stages below:

1. Save onto computer.
2. Fill the name of the hospital collecting the information at the top of the data sheet.
3. Complete each cell from column D to Z answering with the following key. The total will automatically be added for you

   NO = 0 YES = 1 Not known = NK

4. The data base then continues with the **Referral process**
5. Please complete columns AB to AT with the same key

   NO = 0 YES =1 Not known = NK

6. **Save your work** after completing your data input
7. This database will periodically be requested by the researcher.

Researcher : Lynn Lynch
Consultant midwife
Maternity Unit
Prince Charles Hospital
Merthyr Tydfil
CF47 9DT
Tel: 01685 728541 / 07789504764

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Bwrdd Iechyd Cwm Taf Health Board

INTERVIEW SCHEDULE

Introduction, including how long the interview will last, what to expect, clarity whether the interview can be taped. Discuss confidentiality and support that is available if required.

- Did you expect to be asked about domestic abuse in pregnancy?
- Did it offend you to be asked about domestic abuse?
- What made you decide to disclose on this occasion?
- Can you remember whom were you referred to?
- What did you find helpful following your disclosure?
- What was not helpful?
- Looking back if asked again would you disclose?
- Is there anything you would like to add?
- How do you feel now?
- Do you feel you need further support?