Bedford Borough Community Safety Partnership

working together to make communities safer

DOMESTIC VIOLENCE HOMICIDE REVIEW

EXECUTIVE SUMMARY

REVIEW REPORT INTO THE DEATH OF

Ms D

Date of Death: 29 April 2011

Report produced by:

Gaynor Mears OBE, MA, BA (Hons), AASW, Dip SW

Date: 31st July 2012

DOMESTIC HOMICIDE REVIEW

Into the Death of Ms D, a Resident of Bedford Borough

Date of death: 29 April 2011

The report has now been quality assured by the Home Office which used only 2 levels of assessment – 'Adequate' and 'Inadequate'. The Bedford DHR was found to be 'Adequate'. This report is produced by the Bedford Community Safety Partnership and all enquiries about the report can be forwarded to Sally Flint, Communities Manager, Bedford Borough Council, B101 Riverside House, 6 Horne Lane, Bedford, MK40 1PY, tel. 01234 718454, email: sally.flint@bedford.gov.uk.

1. Introduction

1.1 This Review has been conducted in accordance with statutory guidance under Section 9 of the Domestic Violence, Crime and Victims Act 2004. The Review was commissioned by the Bedford Community Safety Partnership following the murder of a Bedford resident in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Act namely, the violence appeared to be by a person to whom they were related or with whom they had or had been in an intimate personal relationship.

1.2 The key purpose for undertaking Domestic Homicide Reviews is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

3. Recommendations:

3.1 The following recommendations are made from the analysis of the available facts known to agencies and the lessons to be learned. The background information and lessons learned follow these recommendations.

3.2 **National:**

3.3 Consideration should be given to including the ACPO CAADA DASH risk assessment into the initial and core assessment processes. Where domestic abuse is alleged or found to be a component of a household or an individual's life, a question asking about the presence of domestic abuse on the assessment should trigger the completion of the DASH and consideration of a referral to MARAC.

3.4 The current time limits on initial and core assessments are too limiting and constraining and have an adverse impact on the quality of the assessment. Consideration should be given to implementing the findings of Professor Munro's review on the current time limits.

3.5 Ms D's family believe more should be done to publicise domestic abuse both aimed at victims and at raising awareness of signs to look out for by family and friends and what they can do to help. They wish to make a recommendation that there should be strong impactful advertisements in a range of media, from billboards to radio adverts which will make people take notice. They should be in a variety of settings including doctor's surgeries and dentists.

3.6 The family would wish to see a more robust approach to offenders who breach their Probation Orders or who break the law further, whether linked to domestic abuse related crimes or not so that a suspended prison sentence is served.

3.7 Bedford Borough Domestic Abuse Partnership

3.8 The Domestic Abuse Partnership is advised to review the extent of the implementation of multi agency domestic abuse protocols and procedures such as the domestic violence guidance and procedures for using DASH and MARAC. Multi agency procedures including domestic violence procedures and guidance should be reviewed to ensure they are brief, focussed and inform practitioners in a straightforward way about what they should do. The status of these protocols and procedures in relation to other single agency assessment processes, needs to be clear. Procedures should be easily accessible so that they are fit for use by busy front line staff.

3.9 The Partnership may find it useful to conduct a multi-agency audit into levels of knowledge and training with regard to the understanding of domestic abuse and its impact, knowledge of risk assessment, and MARAC referral processes. This would assist the planning of a training programme for the Borough.

3.10 In addition to risk assessment and MARAC training the Partnership should ensure that multi-agency training includes identification of domestic abuse, and strategies and resources for working with those affected. This should including safety planning.

3.11 The training course delivered by the Partnership on working with domestic abuse perpetrators should continue to be provided and be publicised. It should be aimed at those practitioners whose work involves assessing or supporting families where the perpetrator is still in the family or has contact.

3.12 The Partnership should review the current process of inter-agency notification of domestic abuse incidents. It is recommended that this review look at notifications across agencies and not just from the Police to Children's Social Care. Consideration should be given to a system which targets notifications safely on a need to know basis, for example a notification sent securely to the specific Health Visitor for the family and/or a children's school Safeguarding Lead.

3.13 Bedford Local Safeguarding Children Board:

3.14. The LSCB may wish to encourage a more consistent and coordinated approach to risk assessment across agencies by reviewing the range of guidance used by agencies and seeking to integrate these processes where possible.

3.15. Multi-agency training should be available on the effects of domestic violence on children for all those working directly with or assessing children.

3.16. Consideration should be given to delivering training in working with hostile families and those who use 'disguised compliance' or other obstructive and avoidant behaviours.

3.17. Consideration should be given to publicising the guidance and pathway to seeking a paediatric medical opinion in cases of injuries sustained by children.

3.18. All Agencies:

3.19. Where domestic violence is identified during an assessment or other agency activity this should trigger the completion of the DASH risk assessment. This should be completed with the victim unless it is unsafe to do so to ensure that the most up to date and accurate assessment can be made. Where information is not available from the victim, for example previous criminal history, this may need to be sourced from another agency to complete the full picture of risk. Familiarisation with the DASH risk assessment checklist and its use is relevant for all agencies.

3.20. Training in the DASH risk assessment and referral process to MARAC should be provided on a regular basis and all professionals and their managers in frontline services who work with families or individuals affected by domestic violence should attend whether statutory or voluntary sector, and organisations such as Housing Associations. This training should include a full explanation of the DASH and the evidence which underpins it so that practitioners understand the full implications and reasoning behind the assessment tool. The outcome should be that all professionals are confident in its use and in the referral criteria and methods of referral to MARAC.

3.21. Agencies working with families or individuals where domestic violence is present or suspected are recommended to keep a chronology of significant events and up to date records to detect patterns, escalation, new risk indicators such as pregnancy, and rising levels of risk.

3.22. Multi-agency services working with children and families should ensure that staff undertake domestic abuse training to increase their understanding and identification of domestic abuse, and the strategies and resources available for working with those affected. This should including safety planning.

3.23. Agencies who work directly with families should ensure that their staff are given training in working with hostile families and those who use 'disguised compliance' or other obstructive and avoidant behaviours.

3.24. Managers and Supervisors should ensure that their staff whose work involves assessing or supporting families where the perpetrator may still be in the family or has contact, receive training on working with perpetrators of domestic abuse.

3.25. Practitioners should be supported by their Managers and Supervisors to gain confidence in debating with multi-agency colleagues regarding areas of differences of opinion concerning the way safeguarding children or domestic violence cases are handled. The Local Safeguarding Children Board has in place an agreed escalation process to assist this. Professionals should be supported to recognise that child protection is a multi-agency responsibility and a variety of agencies can request a child protection conference.

3.26. The holding of strategy or professionals meetings to agree and determine the route to be taken with a case on completion of a core assessment should take place in line with procedures. This will facilitate exchange of information, pre planning of meetings which may be confrontational, and increase multi-agency joint responsibility.

3.27. Agencies should be aware that the removal of an abusive partner through legal means, or separation due to the victim ending the relationship is not a time to end involvement or support. Separation represents a heightened risk to victims and children and safety planning and support should be increased at this time, not reduced or ended.

3.28. Social work Teams:

3.29. Seeing and speaking to a child alone when appropriate as well as with parents is important when completing an assessment. This is particularly critical where domestic violence or possible harm to a child is suspected. To minimise distress it is important to see children in an environment where they feel safe. For younger children being seen at school may be appropriate especially where there is domestic abuse in the household where they may have learnt or been threaten to keep secrets.

3.30. Core assessments should include an expectation that the family history of all household members is collected. It is critical that transient male figures are identified and included in history taking. Lack of cooperation by family members is grounds to consider escalating the intervention to child protection processes. Where domestic violence or physical abuse is a possible issue keeping safe work should be undertaken with the victim and the children separately.

3.31. When gathering information from other agencies Social Workers should ask for a full chronology of events and concerns at least in the last year, and for criminal background seek full disclosure of any known history. Where DASH or other assessments have been completed the Social Worker should ask that the agency share full details of the risk assessment. This should be updated with any additional information known to the Social Worker from records. Risk and resilience tools and the DASH assessment tool would be more routinely used by Social Workers if integrated into the current assessment processes. Consideration should be given to doing this.

3.32. Social Work Teams should review the training needs of their staff to identify those needing to access e-learning or more extensive training on domestic violence issues. Those involved in assessments and/or child protection should have a thorough knowledge to ensure that their level of proficiency and understanding is sufficient to enable them to identify domestic abuse, recognise its impact, risk assess, safety plan, and coordinate support safely.

3.33. Social Workers should familiarise themselves with the guidance and pathway procedures for seeking medical advice. The advice of the Paediatrician on the Child Protection Medical Rota should be sought for a child protection or welfare medical when assessing the likely cause of injuries sustained by a child. A more enquiring approach should be used when taking histories of injuries to establish that explanations given are consistent and feasible for the presenting injury. A series of injuries should be assessed thoroughly. This may be more effectively achieved with the benefit of expert medical advice.

3.34. The removal of, or separation from, an abusive partner is a time to support victims and their children, not to close the case. Separation heightens risk, it does not reduce it. Support needs, and safety and security should be addressed at such times to help survivors through this period of adjustment. Personal safety should be a priority following separation.

3.35. The sending of letters to victims, or victims and perpetrators asking them to address their domestic abuse behaviour should be reviewed. This practice has been shown to be ineffective and can cause further abuse of the victim or heighten risk.

3.36. **Schools:**

3.37. Schools should use the Common Assessment Framework (CAF) to support their own assessment of children's needs. This would make their referrals to other agencies more effective. Assessment is a process which should always capture schools in depth knowledge of a child. Schools should review and share their chronology of concerns and ensure these are detailed on referral or following their referral to other agencies.

3.38. Schools should ensure that as a minimum their Safeguarding Lead is knowledgeable about the affects of domestic abuse on children's educational attainment, their behaviour, and other impacts of living in a family where domestic abuse is present. This should be shared with their colleagues to increase knowledge within schools.

3.39. **Education Welfare Service:**

3.40. Casework files (where an official referral has been received) should be kept until the individual pupil has reached the statutory school leaving age. These files should then be archived in line with the Bedford Borough Council policy. Liaison files should be kept for three years.

3.41. **Police:**

3.42. Notifications of domestic abuse incidents to Children's Social Care should be clearly identified as such, especially where the crime committed may not be readily identified as domestic abuse i.e. criminal damage, anti-social behaviour. A DASH risk assessment should be attached to notifications or referrals.

3.43. A more thorough method of flagging domestic violence incidents to the Police Public Protection Unit is needed to prevent these incidents falling through the net, and clarification of closure categories needs to be given to frontline Officers to ensure that incidents are recorded correctly as domestic violence.

3.44. Consideration should be given to formalising a procedure to ensure referrals are made to Children's Social Care and the Child Protection Unit when children are found during Police operations in circumstances which raise concern for their safety and wellbeing; for example during the execution of drugs warrants.

3.45. A system of sending repeat victim cases to the Domestic Abuse Unit would be valuable to consider so that the history of incidents can inform an holistic assessment of risk to identify increased frequency and escalation.

3.46. The 'sig marker' system needs to be reviewed periodically to ensure that the address it holds is accurate for all victims to which it applies. Where there are child protection concerns linked to domestic abuse changes of address should be shared with partner agencies, unless there are safety reasons why the address needs to be kept secure or restricted. Sig markers would benefit from having the addition of the risk status of the victim, and if the case has been to MARAC this should be highlighted so that repeat victimisation can be referred to the MARAC coordinator or the lead professional for that case.

3.47. Consideration should be given to a triage system for reviewing and assessing incidents to identify repeat victims who may appear low or medium risk, but where incidents are escalating in frequency or seriousness so that incidents are not viewed in isolation and are thus at risk of being overlooked. A variety of agencies, not just the Police, will have knowledge of these cases therefore multi agency coordination of this process would be helpful.

3.48. Probation:

3.49. Probation Officers should ensure that information is shared with Children's Social Care as soon as possible where children are in the household of an offender on IDAP and they are breached for non attendance or behaviour which increases risk to their partner or former partner, such as increased use of alcohol or drugs which has been a previous risk factor in assaults.

3.50. For those offenders without children, or where the family is unknown to other agencies, consideration should be given as to how a new increase in risk posed by an offender can best be mitigated to reduce the risk to the partner, former partner, or children.

3.51. This Review acknowledges that Bedford Probation Trust has taken action concerning the consistency of enforcement action following its own internal enquiry, and has issued a detailed briefing to all staff regarding information sharing and risk management within a safeguarding framework. This Review would reinforce the importance of a consistent and robust approach to enforcement action for breaches by those on IDAP.

3.52. Health Agencies:

3.53. The complex and multi-layered structures within Health can pose barriers to effective communication and clarity of responsibility. All professionals need to take personal responsibility for acting on their concerns for a patient's wellbeing and safety, be that for a victim of domestic abuse or the safeguarding of children. Staff raising concerns should expect to have feedback to confirm the actions taken and who is responsible for those actions. Clear lines of responsibility and accountability are needed for staff.

3.54. All medical professionals should take a more enquiring and questioning approach when taking histories of injuries to establish that explanations given are consistent and feasible for the presenting injury. If establishing the aetiology of the injury is outside the scope of the practitioner examining the patient a suitably qualified practitioner's opinion should be sought.

3.55. Hospital:

3.56. Where concerns are raised about a domestic abuse/safeguarding issue during the maternity period this should be recorded in the hospital notes of any children in that family who have accessed Bedford Hospital.

3.57. Effective and timely communication between Community/Hospital Midwives and Health Visitors should take place. This is to ensure that information about domestic abuse or safeguarding issues are shared to facilitate safety planning (a discrete activity undertaken with a victim of domestic abuse), and risk reduction during pregnancy or for those in the post natal period.

3.58. Notification of children treated in Accident and Emergency or admitted for treatment should take place between the Safeguarding Liaison post and the patient's GP.

3.59. Community Health:

3.60. Health Visitors

3.61. Consideration needs to be given to affecting a more timely access to archived Health Visitor case notes to facilitate the smooth transfer and access to previous case history notes to a new case holder, to inform case management, and decision making regarding children and families.

3.62. A more coordinated approach to Health Visitor and GP communication is recommended where safeguarding concerns can be shared and agreed actions and outcomes can be clearly recorded and accounted for.

3.63. Although supervision has totally changed since the early days of this case, consideration may need to be given to how Community Health Service 0-19 years team professionals identify cases for safeguarding supervision. Therefore a review of the oversight of caseload management by 0-19 years Team Leaders needs to be undertaken with a view to the development of guidelines to support this process.

3.64. Health Visitors may wish to consider a system of taking all their safeguarding children cases to supervision on a regular basis. Health Visitors should also access their Named Nurse for Child Protection when they feel the need to discuss issues of concern between supervision sessions if their Line Manager is not available.

3.65. General Practitioners

3.66. GPs may wish to consider the use of a communication tool such as SBAR (Situation, Background, Assessment, Recommendation)[1] to facilitate, recorded, productive discussions in Health and other organisations. This communication tool will ensure that there are no misunderstandings between agencies when agreeing appropriate actions and responsibility for actions are identified from the outset.

3.67. GPs should familiarise themselves with the DASH risk identification checklist, and with the referral pathway to MARAC to enable them to make appropriate referrals where a patient is identified as high risk.

3.68. If a patient is identified as being at risk of harm (missed appointments, unexplained injuries and maternal concern around minor complaints) the information should be shared with other appropriate agencies and Children's Social Care as needed.

3.69. Where children are seen to be missing a substantial number of appointments for immunisations, clinic appointments, and other medical or developmental assessments, thought should be given to discussing these concerns with the named Health Visitor for the GP surgery and/or Children's Social Care.

3.70. Health Visitors need to be kept up to date on children's attendance at A & E and hospital admissions to enable them to support children and families effectively. GP's are recommended to take steps to ensure that this takes place following their notification of such admissions from the hospital.

3.71. GP's are recommended to consider the efficacy of the current GP electronic data entry system and to identify areas where the system could be improved. For example data entries should include clear historical accounts of the patient and detailed documented evidence of patient examinations and contacts.

[1] www.institute.nhs.uk/safercare

3.72. GPs would find it useful to access the Royal College of General Practitioners e-learning course for guidance and practice advice regarding domestic violence. This is available on the Royal College's website[2] at: http://elearning.rcgp.org.uk/course/view.php?id=88.[3]

8. Lessons to be drawn from the case.

8.1 Inter-Agency Coordination

8.2 Working with families where domestic violence is present needs effective coordination and systems in place to enable this to happen. As is evident from this Review many agencies were involved with Ms D and her family over the years; often they were working in isolation, with their own pieces of information and fulfilling their own agencies aims and priorities. This demonstrates the complexity of need and the resources required to support and protect victims and their children, and to monitor and challenge those carrying out the abusive and controlling behaviour.

8.3 Unless a case is referred to MARAC and the IDVA Service where safety plans are developed and coordinated, there appears to be no coordinated and streamlined system of assessment and delivery of services to victims, whichever agency they are known to. Knowledge and understanding of domestic abuse in many agencies appears to be inadequate to ensure staff feel confident to deliver safe effective practise in this challenging area.

8.4 A more coordinated approach across agencies is needed to ensure that services work together with victim safety at the centre of their work.

8.5 Information Sharing:

8.6 Sadly, in common with many previous Reviews into the deaths of vulnerable adults or children, ineffective or lack of information sharing is a key factor and a lesson which must be repeated here. Although there was evidence of information sharing on occasions it was not always comprehensive, timely, and two way between agencies.

8.7 Effective recording and chronologies are a vital tool for communicating effectively. Without information of the history of events as well as the most recent incidents it is impossible to undertake comprehensive assessments to identify trends, patterns, and escalating risk. Coupled with this is the need for thorough analysis of the events and patterns to identify areas of heighten risk or possible triggers for escalation. As analysis of Ms D's history showed key events such as 999 calls were closely linked to a new pregnancy or not long after a birth. Assessments are of no benefit if they are not accompanied by effective analysis.

[2]Violence Against Women and Children: an RCGP online course can be accessed at the RCGP website at: http://elearning.rcgp.org.uk/course/view.php?id=88 (registration required).

8.8 Information sharing needs to be undertaken fully and safely in domestic violence cases and the best method of doing this for high risk cases is via the MARAC.

8.9 In this case the decision to hold the case at Child in Need instead of Child in Need of Protection was not in the best interests of the children. It is easy to become drawn into seeing domestic violence as an issue affecting adults and to overlook the affect it is having on children. It is important to stand in the shoes of children and imagine what they are hearing and seeing, and what they may be experiencing as a result. By holding this case at Child in Need level not all the core agencies involved in safeguarding were around the table. This led to a lack of information sharing and processes to inform risk assessment and then to manage that risk. Operating under Child Protection procedures also gives greater powers to professionals to work with uncooperative or evasive parents.

8.10 Information concerning the high number of 'did not attends' for medical appointments for the victim and the children, including important childhood immunisations, remained with the GP surgery, apart from one occasion when the Health Visitor was asked to follow up on the children's missed immunisations. Such high levels of missed appointments were worrying omissions. Similarly, the children's high level of absenteeism and lateness, and their behaviour at school was not followed up. Professionals must take responsibility for escalating such concerns and welfare matters appropriately.

8.11 Risk Assessment:

8.12 Although professional judgement should never be ignored or overlooked, the use of an evidenced base risk assessment tool such as the DASH is a very useful indicator for assessing the risk faced by victims of domestic violence and abuse. All professionals involved in cases of domestic abuse need to be practised in its use and understand the background evidence for the components which make up the assessment. Professionals working with children may also wish to consider the Barnardos Multi Agency Domestic Violence Risk Identification Threshold Scales for assessing risk to children living with domestic violence.[4]

8.13 Dividing up the top tier of risk into 'high' and 'very high' is unhelpful. It heightens the likelihood that high risk cases will be downgraded and as a consequence they will slip through the net and not be referred to MARAC.

8.14 A method of triaging incidents to identify repeat victims who may appear low or medium risk, but where incidents are escalating in frequency or seriousness needs to be found so that incidents are not viewed in isolation and as a consequence are at risk of being overlooked. A variety of agencies, not just the Police, will have knowledge of these cases therefore multi agency coordination of this process would be most helpful.

[4] See pilot study Policy and Practice briefing at http://www.barnardos.org.uk/p_p_briefing_no.7.pdf

8.15 Risk assessment needs to be undertaken as soon as possible and with the victim. It needs to be reviewed periodically to reflect changes in the victim's life or the offender's behaviour.

8.16 In addition to the victim's input, the risk assessment may need additional facts from the holders of information not known to the victim or the agency completing the assessment.

8.17 For a referral to be useful a DASH risk assessment needs to accompany that referral. The receiving agency needs as much information as safely possible. Where a referral for a domestic violence case is not due to a violent incident, such as criminal damage or anti-social behaviour, it helps the receiving agency to know the context and have the domestic violence connection made clear. Information concerning breaches of bail conditions or restraining orders should be flagged.

8.18 Concerning the current DASH risk assessment component asking the question 'are you currently pregnant or have you recently had a baby (in the past 18 months); the Police Independent Management Review recommends that splitting this question into two separate questions would be helpful. However, both these conditions carry equal weight in terms of heightening risk, and amending the risk assessment in this way would involve recalibrating the criteria for MARAC and IDVA referral. The risk assessment checklist contains space for additional comments, and officers could add a note to distinguish whether the victim is pregnant or recently had a baby.

8.19 Early and Timely Intervention to Support Victims:

8.20 It is a well known fact that victims of domestic abuse will have suffered up to 35 incidents before they make a report. Therefore, early intervention and support are vitally important. This would include the offer of increased home security and support from a specialist domestic violence agency, such as Women's Aid or a refuge that provides outreach. High risk victims should always be referred to the IDVA service and MARAC.

8.21 Absence of the offender is the time to act not to close the case. If an offender is in prison, subject to a restraining order, or has bail conditions not to contact the victim, this is the time to actively engage with the victim and any children in the household. Support in this important period of adjustment needs to aid recovery from the abuse practically and emotionally to help victims and children to make a new life.

8.22 The Importance of Domestic Abuse Training

8.23 There is still a lack of recognition of the other forms of domestic abuse other than physical violence. This may be because agencies such as Children's Social Care receive a majority of their referrals from the Police and they are primarily derived from violent incidents which constitute a crime. Greater awareness and the ability to recognise all forms of domestic abuse and controlling behaviours used by perpetrators, in addition to the affects on adults and children are required.

8.24 Whilst criminal justice agencies are used to dealing with offenders other agencies involved in supporting families such as Health, Education, and Social Care, are not so adept or confident in this field. This can lead to an inability to challenge and confront perpetrators of domestic abuse. Training in this area would increase the confidence of those who are involved with families where the perpetrator is present or in contact with their children.

8.25 Multi-Agency training in the practise of the DASH risk assessment and referral pathways to MARAC is needed. There is still widespread ignorance of both these mechanisms for supporting high risk victims in the area.

8.26 **Accountability, professional confidence and 'respectful uncertainty[5]'**

8.27 There were occasions when professionals had information and concerns, but did not act on them because the assumption was that another professional was taking action. However, no one was. All professionals have responsibility for, and are accountable for, acting on their concerns whether to safeguard children or for the safety of a victim of domestic abuse. Systems in agencies need to be clear to support staff to do this.

8.28 There were occasions when some professionals clearly felt ill-informed or lacked enough knowledge of the system to feel confident to question or contest decisions being made. Multi-agency professionals should have the confidence to engage with colleagues in respectful debate when decisions are made with which they disagree, or where they feel they have a lack of sufficient information or evidence to make an informed decision.

8.29 Policy guidance on holding strategy meetings or professionals meetings appear not to have been followed. This meant colleagues in other agencies were not able to contribute to decision making on the direction of travel particularly with regard to Child in Need or Child in Need of Protection decisions.

8.30 **Focus on the Children:**

8.31 Where there is a longstanding, chronic history of domestic violence care is needed not to loose focus on the children's experience and the effects on their development and wellbeing. It is tempting to believe that nothing will change and nothing can be done to invoke change. This acceptance of the problem risks reflecting the psychological damage and behaviour of the long term victim of domestic abuse. Children must not be overlooked in these circumstances and should be given protection and support.

8.32 None of the children who had bruises, grazes, or injuries were examined by the Community Paediatrician to seek a medical opinion as to the cause of their injuries. The parent's explanation was always accepted. Neither Social Workers nor Teachers are experts in assessing injuries and their possible cause, and even when an injury on its own appears minor in nature, a series

[5] Bedford Borough Safeguarding Children Board (2003) *Resolution of professional disagreements relating to the safeguarding of children & the escalation of professional concerns*

of similar minor injuries such as bruising and grazes especially to the head should have a medical examination and the opinion of a Paediatrician.

8.33 Those treating children's injuries need to take a more enquiring approach to taking histories of injuries. Questions should be asked to establish that explanations given are consistent and feasible for the presenting injury. Previous history, especially of similar injuries, should be taken into account and analysis of possible patterns of injuries i.e. time and place should be noted.

8.34 Working with Uncooperative Families

8.35 Practitioners working with uncooperative families and those who use 'disguised compliance' or other obstructive and avoidant behaviours are working with the most demanding cases. These professionals need access to training for the best ways of working with such families and access to regular and supportive supervision to manage the effects on themselves of this work.

GLOSSARY OF TERMS

A & E	Accident & Emergency Department
ACPO	Association of Chief Police Officers
CAADA	Coordinated Action Against Domestic Abuse
CAF	Common Assessment Framework
CPS	Crown Prosecution Service
DASH	Domestic Abuse Stalking and Harassment (Risk Assessment Checklist)
DAU	Domestic Abuse Unit
DHR	Domestic Homicide Review
GP	General Practitioner
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IMR	Independent Management Review
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
PPU	Public Protection Unit
SPECSS	Separation, Pregnancy, Escalation, Community/Cultural issues, Sexual Assault (SPECSS = mnemonic for risk assessing these issues)