Greater Manchester Police's approach to tackling domestic abuse

HMIC revisit 3-5 November 2014

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Introduction

This report sets out Her Majesty's Inspectorate of Constabulary's (HMIC's) findings following our revisit to Greater Manchester Police in November 2014 to assess progress made against the nine recommendations in the report published on 27 March 2014: *Greater Manchester Police's approach to tackling domestic abuse.*

Summary of the revisit findings

The force has invested a considerable amount of time and resource to improve its response to victims of domestic abuse following the publication of HMIC's original report in March 2014. The chief officer team have made tackling domestic abuse the priority for the force. Our revisit found widespread evidence of increased focus on domestic abuse across the force from the time that calls were received by call handlers through to the initial response of frontline staff and the ongoing involvement of supervisors and specialist units.

The force has acknowledged the areas of risk identified in our original report and we found evidence that the force has put measures in place to enhance service delivery to victims and make people safer. Identification of victims, particularly vulnerable and repeat victims, has improved.

There is a greater appreciation of the need to safeguard victims by frontline officers and staff who provide the initial response to victims of domestic abuse. However, greater clarity is still required to ensure that all staff fully understand their responsibilities for ensuring the safety of victims at every stage of the investigation process, particularly where an offender has been charged.

The public should feel reassured that the force is taking the necessary steps to provide effective safeguarding measures for all victims of domestic abuse.

Our findings in response to each of the nine recommendations are set out from page 10.

HMIC 2013 Domestic Abuse Inspection

In September 2013, HMIC was commissioned by the Home Secretary to inspect the police response to domestic violence and abuse. Our report, *Everyone's business: Improving the police response to domestic abuse*, found that while most forces and police and crime commissioners said that domestic abuse was a priority for their areas, this was not being translated into an operational reality. HMIC was concerned to find that, despite the progress made in this area over the last decade, not all police leaders were ensuring that domestic abuse was a priority in their forces and that it was often not given the same level of priority as other policing activity.

We were asked to consider:

- the effectiveness of the police approach to domestic violence and abuse, focusing on the outcomes for victims;
- whether risks to victims of domestic violence and abuse are adequately managed;
- identifying lessons learnt from how the police approach domestic violence and abuse; and
- making any necessary recommendations in relation to these findings when considered alongside current practice.

To answer these questions, HMIC collected data and reviewed files from the 43 Home Office funded forces. We spoke to 70 victims of domestic abuse in focus groups throughout England and Wales and surveyed over 100 victims online. We also surveyed 200 professionals working with victims of domestic abuse. We inspected all police forces in England and Wales, interviewing senior officers and operational leads, holding focus groups with frontline staff and partners, and carried out visits to police stations (which were unannounced) to test the reality of each force's approach with frontline officers. Our inspection teams were supplemented by external staff, including public protection experts from over 15 forces and those working with victims of domestic abuse in voluntary and community sector organisations.

HMIC inspected Greater Manchester Police between 4 and 7 November 2013. The report was published on 27 March 2014.

HMIC's inspection of Greater Manchester Police in November 2013 raised significant concerns about its ability to deal consistently and appropriately with victims of domestic abuse and to reduce the risk of harm to them. Domestic abuse was a stated priority for both the police and crime commissioner (PCC) and the force and we found that they had invested in skilled and experienced specialist domestic abuse

teams. However, these teams dealt only with those victims deemed to be at the highest-risk, and who represented a small proportion of all domestic abuse victims. The remainder were dealt with by other police teams.

HMIC found serious weaknesses in the understanding of staff about their role and in the processes and systems to manage the risk to victims and keep them safe. The focus was on dealing with the offenders, with insufficient attention paid to safeguarding the victims.

Given the scale and the seriousness of the areas for improvement, HMIC concluded that urgent action was needed by the force to address the risks identified in its March 2014 report.

Identifying victims

Most requests for police assistance in domestic abuse incidents are identified through calls to the force operational communications room (OCR). During the original inspection, HMIC found that call handlers were confident and empathetic when dealing with victims of domestic abuse. However, both they and dispatchers were found to have received only limited specific training in dealing with domestic abuse. All OCR staff understood that domestic abuse should be dealt with as a priority and victims should receive prompt police attendance. There was, however, lack of clarity over the definitions of repeat and vulnerable victims and how this might affect the priority level given to the response.

The force had systems within the OCR which identified repeat calls from the same address or telephone number, but those systems did not readily identify any history either to the victims or by offenders by name. This meant that officers were attending incidents without knowing the full details about previous calls made by the victim, which may have led to them inaccurately assessing the risk presented at each incident.

Keeping victims safe

Domestic abuse is a stated priority for the PCC and the force. However in the 2013 inspection, HMIC found serious weaknesses in the way the force responded to victims and how they managed their safeguarding.

The inspection found that high-risk victims, who were managed by the specialist domestic abuse team (the public protection investigation unit (PPIU)) received a comprehensive response from the police, and their safeguarding was well managed. However, for those victims assessed at standard or medium risk, which represented around 90 percent of all cases, the force could not be confident that all victims were getting a consistently good service.

There was only limited supervision of the initial response to these incidents, training for staff in domestic abuse was inconsistent, with officers focusing on dealing with the perpetrator and not the victim.

HMIC was concerned to find that the levels of service to black and minority ethnic victims were weak and that the force should take urgent action to ensure that victims who needed the service of an interpreter were not disadvantaged.

Management of risk

HMIC found that in high-risk cases managed by the specialist unit, there was a robust and effective process for ensuring the victim was safeguarded but where investigations were led by other teams it was less robust. We were concerned that due to lack of clarity among officers about responsibility for safeguarding victims assessed as standard and medium risk, there was a gap in the level of safeguarding provided to victims. HMIC was concerned that insufficient attention was being paid to maintaining effective contact with victims and managing their safety, with the focus being on dealing with the perpetrator.

The force worked well with local partners through the multi-agency risk assessment conferences (MARACs) where agencies come together to discuss high-risk cases and agree a co-ordinated response to keeping victims safe. However, we found that the increasing number of referrals to some MARACs meant that these referrals were at risk of becoming unsustainable. HMIC acknowledged that partnership working arrangements are complex and challenging in such a large force area but this meant that there were inconsistencies in the range and quality of partnership services available to victims which depended on where they live.

Organisational effectiveness for keeping people safe

HMIC was concerned to find that there were weaknesses in the force's systems and processes which meant that potentially they were failing to manage risk effectively and adequately safeguard victims. Although all victim risk assessments were reassessed by specialist domestic abuse officers, there were significant delays in reviewing the risk assessments during peak times. This delay presented a risk that victims may not be receiving help from the police and partner organisations to help safeguard them when they needed it.

With the exception of high-risk cases, there were no clear processes to ensure that contact was maintained with victims, or that levels of risk were being reviewed as circumstances changed. While everyone was clear who was responsible for dealing with the offender, there was confusion among response officers and prisoner processing officers as to who had responsibility for maintaining contact with the victim.

There were only very limited processes in place to manage serial and serious perpetrators of domestic abuse to prevent or reduce their further offending and the management of these perpetrators was inconsistent across the force.

The force had seen an increase in the number of domestic homicides. While reviews had been carried out, the learning points from them had not been systematically fed through to frontline officers and supervisors or led to improvements in practice.

HMIC found little evidence that monitoring and data collection in respect of domestic abuse performance was being used in any meaningful way to evaluate outcomes for victims or to bring about improvements in services.

Greater Manchester Police Domestic Abuse Revisit 3-5 November 2014

Introduction

As a result of the concerns identified during our inspection of domestic abuse arrangements in Greater Manchester Police in 2013, it was decided that a revisit would take place in 2014 to assess progress made against the nine recommendations made by HMIC in our report Greater Manchester Police's approach to tackling domestic abuse (March 2014).

During the revisit, we used the same inspection criteria as in the original inspection:

- the effectiveness of the police approach to domestic violence and abuse, focusing on the outcomes for victims;
- whether risks to victims of domestic violence and abuse are adequately managed;
- identifying lessons learnt from how the police approach domestic violence and abuse; and
- making any necessary recommendations in relation to these findings when considered alongside current practice.

To answer these questions, HMIC reviewed Greater Manchester Police's domestic abuse-related documents. These included the domestic abuse policy, which had been revised since the original inspection; the continuous improvement action plan created in response to the March 2014 report; and performance management data in respect of domestic abuse incidents. We spoke to chief officers, senior managers (including those from the force's public protection division) and carried out visits to police stations (which were unannounced) to test the reality of the force's progress in promoting understanding of procedures, roles and responsibilities and how these made victims safer.

Revisit findings set against the recommendations from the March 2014 report

1. **The force should review processes at first point of contact to ensure all relevant information on previous incidents is easily accessible and to inform the assessment of risk. In addition, to clarify and apply definitions of 'repeat victim' and 'vulnerable victim' to ensure that they can better identify those most at risk and provide an appropriate response.**

The revisit found that the force has provided training to all first contact staff, including call takers, radio dispatchers, crime recorders and switchboard operators regarding domestic abuse and the identification of vulnerability. We found that staff in the call handling and dispatch centres routinely asked callers about any previous incidents. It was evident that, while the training had focused on domestic abuse, operators were applying their learning to understand callers better and identify the vulnerability of callers, irrespective of the nature of their call.

Force computer systems currently are incapable of automatically identifying and flagging repeat callers. Call handlers and dispatchers research these systems to identify previous incidents. The force has introduced a risk support team (RST) within the control room who provide fast-time research on incoming domestic abuse incidents. This enhanced information about victims, perpetrators and previous incidents is appended to the incident log and transmitted to attending officers. When capacity allows, the RST research background information on other incidents where the caller has been identified as vulnerable.

We found that, in accordance with force policy, domestic abuse incidents are consistently graded to receive a priority response, either Grade 1 (attendance within 15 minutes) or Grade 2 (attendance within 60 minutes) with an escalation process built in which allows for unattended domestic incidents to be referred to divisional supervision for resourcing decisions. There was a good level of supervisory oversight of domestic abuse incidents within the control room.

2. **The force should clarify roles and responsibilities of the various teams involved in dealing with domestic abuse, particularly where victims are assessed as at medium and standard risk, in relation to:**

    - **investigation;**
    - **safety planning;**
    - **keeping victims updated; and**
    - **on-going monitoring and reassessment of risk.**

In October 2014, the force revised its policy in respect of domestic abuse. This now includes the minimum standards expected of all staff when dealing with domestic abuse incidents. Frontline response and neighbourhood officers have received face-to-face training in dealing with domestic abuse incidents, reinforcing these requirements and they have been issued with aide-memoires, clearly setting out expected standards and their responsibilities to keep vulnerable victims safe from harm.

We found strong evidence that frontline supervisors were reviewing the risk assessments and safeguarding decisions made by attending officers. Sergeants are required to review the DASH[1] risk assessment forms completed by their officers prior to submission to the PPIU and this, combined with the focused training, has led to an improvement in the accuracy of risk assessments.

The 2013 inspection identified significant delays in the review of risk assessments by PPIU during peaks in workloads, meaning that safeguarding and support from partner organisations to vulnerable victims might be delayed unduly. During this revisit we found that most areas within GMP continue to struggle to undertake these reviews in a timely manner.

PPIUs operate a triage system, with a member of staff dedicated to reviewing incoming risk assessments and making any identified referrals to other agencies. In spite of this, many PPIUs have a backlog which means that standard risk DASH referral forms are not being processed quickly enough, which in turn means that some victims of domestic abuse are facing unacceptable delays in referral to support services.

To address this problem a number of PPIUs have temporarily stopped dealing with domestic abuse prisoners while others are deploying staff on overtime in an effort to clear outstanding backlogs.

At the time of the revisit the force was running a pilot scheme at Stockport, to improve the standard of risk assessment and decision making and allow officers to

[1] Domestic Abuse Stalking and Harassment

finalise DASH forms for those incidents assessed as standard risk, which if successful would assist in reducing backlogs. The pilot has been supported by training to frontline staff to ensure that they fully understand the referral process and the range of support services and interventions available. This training has introduced the RARA risk management tool, in which officers consider the options to Remove, Avoid, Reduce or Accept the risk.

Evaluation is built in to the pilot and the force should satisfy itself that this approach does not have an adverse effect on the support provided to victims before considering any expansion to other areas.

Recommendation

> Not later than 30 June 2015, the force should review the current processes and level of resources within PPIUs to ensure that the force is able to assess and respond to risks presented to victims at the earliest opportunity, to keep them safe and work effectively with partner agencies.

3. **The force should ensure that independent, professional interpreter services are available for domestic abuse victims and offenders and that all frontline officers and supervisors have an understanding of when and how they should be used.**

The force has undertaken a review of interpreter services provided by an external partner. The review found that the force received a good quality service with only isolated problems with a small number of languages.

The review also identified many staff were unaware of how the service operated. To address this lack of awareness the operational information system (Sherlock), used by staff in the control rooms, has been refreshed with simple instructions on how the interpreter service functions and how it can be accessed. Additionally, all frontline staff have been issued with aide-memoires on how to access interpreter services. While awareness of frontline staff has increased, the revisit identified a small number of isolated cases where initial responders had resorted to using children and other family members to act as interpreters in order to obtain an initial account of what had happened from the victim. This does not reflect the national guidance which states that the use of family members or children should only be used as a last resort. This practice is unacceptable and should be strongly discouraged.

4. **The force should review the supervision by first-line managers of all domestic abuse incidents, to ensure that there is appropriate oversight and quality control of the risk assessment and safety planning at the initial attendance and that the quality of initial evidence gathering and handover can be assured.**

The revisit found that the level of supervision of domestic abuse incidents has improved significantly. Within the communication rooms, supervisors routinely dip-sample domestic abuse calls to assess the quality of caller interrogation and the accuracy of information recording, including the identification of vulnerability and repeat victims.

There is an escalation process in the control room under which any domestic abuse incident that has not been attended within the target time (15 minutes for Grade 1 and 60 minutes for Grade 2) is raised with divisional supervision to identify an appropriate resource that may be deployed to attend the incident. We found that this process was generally effective in securing resources for the more urgent Grade 1 incidents; however, it was clear that some areas of the force regularly struggle to resource Grade 2 calls.

In accordance with the revised domestic abuse policy, we found significant evidence from across the force area, that sergeants are being intrusive in their supervision of domestic abuse cases. Supervisors are making contact with attending officers while they are still at the scene, predominantly by radio but occasionally by personal attendance. Sergeants are checking officers' risk assessments, immediate safeguarding actions and their strategy for dealing with offenders. Supervisors are also checking incident logs to ensure that appropriate investigative actions have been undertaken and any identified offence has been recorded correctly as a crime.

Body worn video cameras are currently deployed in Manchester North and Manchester South. Where they are available we found that they are routinely used by officers attending domestic abuse incidents. Officers we spoke to considered that the use of this technology provided supportive evidence to corroborate the accounts of victims at domestic abuse scenes. We were told by staff from both divisions that audio and video evidence is being used to support successful prosecutions, even where victims are reluctant or refusing to cooperate with police investigations. The force is considering making body worn video devices available to officers across the force.

5. **The force should conduct a training needs analysis and develop a training development plan to include all those involved in dealing with domestic abuse. It should ensure that all relevant staff and officers are equipped with the skills and knowledge to identify domestic abuse in all its forms, undertake risk assessments, manage offenders and safeguard victims.**

The force has completed a training needs analysis, which has been used to inform a two-year training plan. The force has already provided face-to-face training to more than 4,000 frontline staff, including 560 members of the special constabulary. The training is in the form of ten modular sessions, each designed to be delivered in 10 minutes, covering: the definition of domestic abuse; safeguarding; coercion and control; DASH forms; domestic violence prevention orders and notices; victim's code of practice, special measures and achieving best evidence; domestic violence disclosure scheme; female genital mutilation; honour-based violence and forced marriage; and stalking and harassment. The training sessions are stand alone modules, which provide a short, sharp input on the particular subject matter and which can be delivered to large groups of officers in a short space of time.

The force has also commenced a series of response team training days, in which guest speakers have provided an input to officers on how their lives have been devastated through domestic abuse and how the response of the police is critical in supporting the needs of the victim and their family. At the time of inspection five events had been held reaching around 600 officers.

Bespoke training has also been provided to communications staff including switchboard operators, crime recorders, call takers and radio dispatchers on the identification of vulnerability and repeat victims. Although this training was focused on domestic abuse, it has had wider benefits in raising awareness of vulnerability as a key theme.

It is understood that the force plans to increase the number of continuous professional development (CPD) opportunities for staff working in specialist roles. However, a significant proportion of specialist staff in PPIU and the prisoner processing unit (PPU) reported having received no specialist training for some time. This included officers dealing with more serious offences (such as assaults where serious levels of injury are inflicted), who have not completed the initial crime investigation development programme (ICIDP).

Recommendation

> Not later than 30 September 2015, the force should conduct a skills audit of specialist staff working with domestic abuse victims and perpetrators to ensure that they have the appropriate operational skills and competence to conduct effective investigations and keep victims safe.

6. **The force should work closely with the PCC to support the commissioning arrangements for victim services, in particular, to ensure the consistent and sustainable provision of the Independent domestic violence advisor (IDVA) service across the Greater Manchester area.**

The PCC has reviewed the provision of IDVA services across the Greater Manchester area and is exploring how these services can be delivered more consistently to improve the level of support offered to victims of domestic abuse. There are currently 38 IDVAs employed by the different local authorities across Greater Manchester, who are commissioned through a variety of funding streams. The force is working with the PCC to develop a service that ensures the availability of IDVAs, according to the needs of the victim, at the earliest opportunity across all Greater Manchester. On 31 October 2014, the PCC gained support to develop victim services from the Greater Manchester Combined Authority. We will be interested to see how IDVA services continue to develop across Greater Manchester in the near future.

The PCC recently commissioned the charity Victim Support to deliver a service for domestic abuse victims in accident and emergency departments in Tameside. The purpose was to identify and provide support to victims of unreported domestic abuse. Of the first 52 cases identified by staff, nine were of such seriousness that they were referred into the multi-agency risk assessment conference (MARAC) process for cross-partnership consideration and safety planning for the victim. Following a successful bid for additional funding from the Ministry of Justice, it is now intended to expand the project force-wide and provide a similar service in other hospitals.

7. **The force should work with partners to review the current workloads of the MARACs across the force area, and consider alternative meeting cycles to limit the number of referrals to each conference and ensure the process remains effective.**

The volume of cases considered by the 12 MARACs that cover the force area varies. However, it is accepted that the high number of current cases cannot be properly considered in a single monthly meeting. Some MARACs have already moved to more frequent meetings to ensure demand is met. In Wigan, for example, where partners are co-located, meetings are held daily. Elsewhere, in Salford, partners meet three times per week and others across Greater Manchester have moved to fortnightly meetings, to ensure more effective consideration and joint action to support those victims deemed to be most at risk. The force is evaluating the various MARAC arrangements and a central co-ordinating role still exists to ensure consistency.

Whilst the introduction of more frequent MARAC meetings will allow representatives to consider fewer cases per meeting, the force needs to ensure that partner agencies have the capacity to attend and properly contribute to these more frequent meetings.

8. **The force should establish an effective mechanism to ensure that the lessons learned from domestic homicide reviews and other serious case reviews can be systematically communicated throughout the force, and that there are robust systems in place to ensure that where improvements in process and practice are needed they are planned, implemented and monitored.**

The detective chief superintendent, Public Protection Division (PPD) has reviewed all domestic homicide reviews from the last two years and assured herself that the appropriate lessons have been fed into the organisation. However, as yet there is no systematic approach to ensuring that such learning is embedded in the force.

The force recognises that further work remains to be done in this area and is introducing a new internal governance structure. This includes a tactical group, chaired by the detective superintendent PPD, to consider recommendations from both domestic homicide and serious case reviews, with oversight provided by a strategic group chaired by the ACC. Additionally the PCC is keen to ensure learning is not restricted to the police but also involves other partners through a multi-agency governance group.

Recommendation

No later than 30 June 2015, the force should introduce a process to ensure that any lessons learned from domestic homicide reviews and serious case reviews are systematically communicated to officers and staff and that there is an effective governance framework in place to ensure that identified improvements in training, processes and practices are planned, implemented and monitored.

9. **The force should ensure that all performance monitoring information is provided to managers and partners in a way that can be clearly understood and used to drive improvements in end results.**

The force has developed a search facility on its IT system, which interrogates and collates information from across a number of existing force computer systems and databases in relation to domestic abuse and presents information in a user-friendly, interactive format. This facility allows users to set search parameters and manipulate data to identify repeat victims, offenders, locations, as well as allowing users to make comparisons over time.

This toolkit provides users with information to allow informed discussion in key areas, including identifying when previous repeat victims are no longer calling the police and also, incidents where criminal acts have been alleged but for which no crime report has been recorded.

The system has only just been developed and staff awareness of it is currently understandably low, however, given the challenges presented by the force's technology systems, the force deserve recognition for developing a system to make more efficient and practical use of the domestic abuse data that is obtained.

Summary

The force has invested a considerable amount of time and resource to improve its response to victims of domestic abuse following the publication of HMIC's original report in March 2014. The chief officer team have made tackling domestic abuse the priority for the force. Our revisit found widespread evidence of increased focus on domestic abuse across the force from the time that calls were received by call handlers through to the initial response of frontline staff and the ongoing involvement of supervisors and specialist units.

The force has acknowledged the areas of risk identified in our original report and we found evidence that the force has put measures in place to enhance service delivery to victims and make people safer. Identification of victims, particularly vulnerable and repeat victims, has improved.

There is a greater appreciation of the need to safeguard victims by frontline officers and staff who provide the initial response to victims of domestic abuse. However, greater clarity is still required to ensure that all staff fully understand their responsibilities for ensuring the safety of victims at every stage of the investigation process, particularly where an offender has been charged.

HMIC will continue to monitor progress against the new recommendations following our revisit of domestic abuse arrangements across Greater Manchester Police, but we recognise the good progress made by the force to date. The public should feel reassured that the force is taking the necessary steps to provide effective safeguarding measures for all victims of incidents of domestic abuse.

Recommendations

1. Not later than 30 June 2015, the force should review the current processes and level of resources within PPIUs to ensure that the force is able to assess and respond to risks presented to victims at the earliest opportunity, to keep them safe and work effectively with partner agencies.

2. Not later than 30 September 2015, the force should conduct a skills audit of specialist staff working with domestic abuse victims and perpetrators to ensure that they have the appropriate operational skills and competence to conduct effective investigations and keep victims safe.

3. Not later than 30 June 2015, the force should introduce a process to ensure that any lessons learned from domestic homicide reviews and serious case reviews are systematically communicated to officers and staff and that there is an effective governance framework in place to ensure that identified improvements in training, processes and practices are planned, implemented and monitored.

Glossary

body worn video camera	video camera, worn on the helmet or upper body of an officer, which records visual and audio footage of an incident
control room	police control or communications room manages emergency (999) and non-emergency (101) calls, and sending police officers to these calls
DASH 2009	domestic abuse, stalking and harassment
domestic abuse, stalking and harassment	a risk identification, assessment and management model adopted by UK police forces and partner agencies in 2009; the aim of the DASH assessment is to help front-line practitioners identify high risk cases of domestic abuse, stalking and so-called honour-based violence
domestic homicide review	multi-agency review that local areas are expected to undertake following a domestic homicide; the process aims to assist all those involved, to identify the lessons that can be learned from homicides where a person is killed as a result of domestic violence, with a view to preventing future homicides and violence
frontline	police officers or police staff who are in everyday contact with the public and who directly intervene to keep people safe and enforce the law; the HMIC publication, *Policing in Austerity: Rising to the Challenge,* 2013 sets this out in more detail
high risk	following a DASH risk assessment, there are identifiable indicators of risk of serious harm; the potential event could happen at any time and the impact would be serious; risk of serious harm (Home

	Office 2002 and OASys 2006): ‘A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible’
IDVA	independent domestic violence advisers or advocates
independent domestic violence adviser or advocate	trained specialists who provide a service to victims at high risk of harm from intimate partners, ex-partners or family members, with the aim of securing their safety and the safety of their children; serving as a victim’s primary point of contact, IDVAs normally work with their clients from the point of crisis, to assess the level of risk, discuss the range of suitable options and develop safety plans
MARAC	Multi-Agency Risk Assessment Conference
Medium risk	identifiable indicators of risk of serious harm, following a DASH risk assessment; the offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse
Multi-Agency Risk Assessment Conference	regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies; by bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the IDVA, a risk-focused, co-ordinated safety plan can be drawn up to support the victim; there are currently over 270 MARACs are operating across England, Wales, Scotland and Northern

	Ireland, managing more than 64,000 cases a year
partnership	collaborative working is established between the police and other public, private or voluntary organisations
repeat victim	victim who reports an incident of domestic abuse to the police on more than one occasion; this is regardless of whether the incidents reported involve the same or different perpetrators; victims who report multiple episodes of abuse for the first time may also be treated as a repeat victim
risk assessment	provides structure and informs decisions that are already being made, based on structured professional judgment; it is only a guide/checklist and should not be seen as a scientific predictive solution; its completion is intended to assist officers in the decision-making process on appropriate levels of intervention for victims of domestic violence
safeguarding	applied when protecting children and other vulnerable people; the UK government has defined the term 'safeguarding children' as: "The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully"
serious and serial perpetrators	if the police receive reports of at least five incidents to the police involving three different victims the perpetrator will be considered a serial perpetrator

standard risk	DASH risk assessment where current evidence does not indicate likelihood of causing serious harm
vulnerable	a person who is in need of special care, support, or protection because of age, disability, or risk of abuse or neglect