



Multi-Agency Risk Assessment Conference (Marac) Guide for GPs

This guidance aims to clarify the role of GPs in relation to their local Multi-Agency Risk Assessment Conference (Marac) to support patients experiencing domestic abuse. It explains:

- High-risk domestic abuse and the Marac process
- How to record the Marac information safely
- How to share the Marac information safely

This guidance supports the *Marac information request: general practice form*.

Section 1: High-risk domestic abuse and the Marac process

About domestic abuse

Each year around 2.1m people suffer some form of domestic abuse: 1.4 million women (8.5% of the population) and 700,000 men (4.5% of the population). We know from the Crime Survey for England and Wales that 4 out of 5 victims of domestic abuse do not tell the police¹ and that women may be more likely to disclose domestic abuse to a health care professional than to the police.² The survey found that 486,720 victims experiencing partner abuse within the last year sought medical attention. **Seeing their GP could provide a vital opportunity for identification and disclosure.**

What is high risk domestic abuse?

High risk domestic abuse³ is a pattern of violence and abuse which presents a high risk of serious harm or homicide to an adult victim (aged 16+).

Victims at high risk are typically identified using the SafeLives' Dash risk indicator checklist⁴, supported by professional judgement. They may also be identified by an escalation in the frequency or severity of abuse. If someone is identified as experiencing high risk domestic abuse, they will be referred to their local Multi-Agency Risk Assessment Conference (Marac). Any known child(ren) will also be discussed at the Marac, although they are not directly referred in their own right.

For many victims at high-risk, GPs will be their only gateway into a Marac, or can help to get them there much sooner.

Initial education about domestic abuse can be accessed through the RCGP e-learning module: <http://elearning.rcgp.org.uk/course/view.php?id=88>. This should be complemented by practice-based training delivered by a local specialist domestic abuse service or by local commissioning of the IRIS programme (www.irisdomesticviolence.org.uk).

¹ ONS (2015), Crime Survey England and Wales 2013-14. London: Office for National Statistics.

² http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-main-results-apr14_en.pdf Page 60

³ In order to respond safely to any patient suffering domestic abuse, it is recommended that you implement the basic guidance outlined in the "Responding to domestic abuse: guidance for general practice".

http://www.safelives.org.uk/sites/default/files/resources/SafeLives_GP_guidance_manual_STG1_editable_0.pdf

⁴ See <http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face>

What should you do if you have concerns about a patient (adult or child) experiencing domestic abuse?

- Enquire sensitively and provide a safe and empathetic first response.
- Ensure the victim's level of risk is assessed by someone with domestic abuse training; this could be the practice's Safeguarding GP Lead or, if the practice has access to IRIS, the IRIS Advocate Educator (AE).
- Speak to your practice's Safeguarding GP Lead if a child or vulnerable adult is involved.
- With the patient's consent, refer the patient to the local IRIS Advocate Educator if the practice has access to IRIS or to the local domestic abuse support service(s).
- Understand the practice's process for responding to disclosure, and know what to do when there is immediate risk of harm to patients and their child(ren). In this situation, urgent action is required which may include any or all of the following:
 - Help the victim contact the police.
 - Contact the local domestic abuse service.
 - Ring the 24-hour National Domestic Violence Helpline: 0808 2000 247.
 - Consider a referral to children's social care.

What is a Multi-Agency Risk Assessment Conference (Marac)?

A Marac is a meeting where multiple statutory and voluntary services meet to discuss victims of domestic abuse (and their child(ren)) who are at high risk.⁵

Local Marac meetings usually take place monthly or fortnightly. They are attended by local agencies (for example the police, social care, health, housing, specialist third sector agencies etc.) who share relevant information. They are not attended by the victim. The Marac's working assumption is that no single agency or individual can see the complete picture of the life of a victim and their child(ren), but all may have insights that are crucial to their safety. In the 12 months following a Marac meeting nearly half of victims make no further call outs to police.⁶

At the Marac meeting, the agencies work together to draw up a coordinated action plan to address the risks faced by the victim and any child(ren), and to disrupt the behaviour of the perpetrator.⁷ The victim's Independent Domestic Violence Advisor (Idva) is a specialist practitioner who works in partnership with other agencies to implement the action plan, mobilising resources on behalf of the victim, or child(ren), to increase their safety. Crucially, they also represent the victim at the Marac, making sure their voice is heard.

What is your role in the Marac process?

The GP's role in relation to the Marac process is to:

- Share relevant information with the Marac.
- Record relevant information on the victim and child(ren)'s records from the Marac, where safe to do so.
- Consider domestic abuse when you next see the victim, child(ren) or perpetrator.

GPs referring to Marac

Although GPs can refer directly to the Marac, using the SafeLives Dash criteria, this assessment is best undertaken by your local specialist domestic abuse service or the police.⁸ The referral form/criteria can be found at safelives.org.uk/gp.

⁵ In 2014 over 76,000 cases were heard at Maracs nationally, fewer than 2 cases per registered GP (35,561 registered GPs in 2014).

⁶ Research from SafeLives (2012)

⁷ Throughout this document, the term 'perpetrator' refers to both those with a criminal conviction and those without.

⁸ Your practice should have a designated person or external domestic abuse service who undertakes this risk identification on your behalf as recommended in the basic guidance. If this is not the case you should ask your MARAC named point of contact for advice.

Before the Marac Meeting: sharing relevant information with the Marac

Your patient's medical record may hold important information about either the victim, the child(ren) and/or the perpetrator which is relevant to the risk identification and safety planning process. This may include details about their mental health, substance use, clinical history or, in the case of a child, their development. It may also include any disclosures made to you about abuse experienced or perpetrated.

Once your practice is signed up to the **Marac Information Sharing Protocol (see page 5)**, you may be notified that one of your patients has been referred to the Marac. When one of your patient's cases is heard at the Marac, you may receive a letter or **case** list from your **Marac point of contact**. It is likely that only a small number of Marac cases will be registered with any one practice.

You will be asked to share relevant information on your patients, via your Marac point of contact, using the **Marac information request: general practice form**. Detailed information regarding what information you will be asked to provide is included within the information request form. You will be asked to provide this information to the Marac point of contact **BEFORE** the Marac meeting, so that the relevant information can inform the Marac and safety planning process.

After the Marac Meeting

Recording Marac Information

After the Marac meeting, your Marac point of contact will send you information from the meeting that is relevant to your patient. Recording the information from the Marac (such as the type and extent of abuse suffered, or the presence of child(ren) at domestic abuse incidents) in the victim's and any child(ren)'s records will help ensure that domestic abuse is considered when they next attend an appointment. **However, it is imperative that this is done safely. Be aware of the potential danger of the perpetrator having access to information as described below (see section below regarding sharing information and patient safety).**

Completing actions

You may also be asked by the Marac point of contact to complete any agreed actions. For example:

- "Mental health problem identified as a risk at the Marac; previously referred to secondary care but did not or could not take up the appointment at that time. GP to review at next attendance."
- "If you become aware of a further incident of domestic abuse within a 12-month period, notify your Marac point of contact and record this **safely** in the patient's notes."

Supporting your patient after Marac

- Consider domestic abuse when the patient next presents, and consider any risks to child(ren) (see: 'What to do you if you have concerns').
- Try to ensure that the patient is seen at appointments **alone**. If the patient is not alone do not discuss domestic abuse or the Marac meeting.
- Ensure information is **recorded safely** in the notes of the victim and child(ren) (see Section 2: recording information).
- Record the domestic abuse in the **electronic medical record**, using the national Read code 'History of domestic abuse' (14XD), so that you and your colleagues can consider the abuse when the patient next attends the surgery.

What is the role of the Marac named point of contact?

The Marac named point of contact will:

- Inform the GP if one of their patients will be discussed at the Marac meeting⁹ and request completion of the information request form.
- Pass on the information that the GP has decided to share with the Marac (For more information about the Information Sharing Protocol see page 4).
- After the Marac meeting, share relevant information with the GP from the Marac about their patient, including any agreed actions.

⁹ Where there is a dedicated health representative for Marac they may also provide a brief summary of the reasons for the Marac referral in advance of the meeting to enable the GP to judge whether any information they hold may be relevant to share.

Section 2: How to safely share information with the Marac

Like all other agencies represented at the Marac, GPs should only ever share information that they consider to be proportionate and relevant to safeguarding either the victim or child(ren).

Consent to share information at the Marac:

Some patients will have consented explicitly to sharing information with their GP and other relevant clinicians.

Where explicit consent to share has NOT been obtained you will have to balance the risk of not sharing information against the need to preserve confidentiality. When a victim has been assessed at high risk of serious harm or homicide, GPs and other services may share relevant information without patient consent:

- If the GP has concerns about the welfare of the child(ren) or vulnerable adult (e.g. those with learning difficulties) and believes they are suffering or likely to suffer harm.
- If there is a risk of serious harm or homicide in not sharing the information¹⁰ (all victims referred to Marac will have already been assessed as experiencing high risk domestic abuse by the agency who referred the case to the Marac).
- Using the below legal grounds for sharing information without consent.

Lawful grounds for sharing without consent¹

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	Schedules 2 & 3, DPA
Right to life Right to be free from torture or inhuman or degrading treatment	Human Rights Act, Articles 2 & 3
Prevention of Abuse and Neglect	The Care Act 2014
Person lacks the mental capacity to make the decision regarding consent	Mental Capacity Act 2005

Whether or not consent has been obtained, the GP must:

- Ensure the information shared is ‘**Caldicott compliant**’ (see below summary of updated Caldicott principles for information sharing).
- Only share information which is relevant and proportionate to the level of risk of harm to a named individual or known household.
- Document any decision to share information (or not) within the patient and child(ren)’s records.

¹⁰ See BMA guidance: <https://www.bma.org.uk/advice/employment/ethics/mental-capacity/vulnerable-adults-and-confidentiality>

Summary of updated Caldicott principles for information sharing:¹¹

The Marac process must comply with **all Caldicott principles** to be correctly implemented, and it is ensured that Marac agencies DO comply with these principles by signing the Information Sharing Protocol (see below). A summary of these principles include:

1. Formally justify the purpose.
2. Identifiable information only when absolutely necessary.
3. Only the minimum required should be used.
4. Need to know access.
5. All must understand their responsibilities.
6. Comply with and understand the law.
7. The duty to share information can be as important as the duty to protect patient confidentiality.

Information Sharing Protocol

There are guidelines governing the information sharing process at the Marac; all engaged agencies are signed up to an **Information Sharing Protocol (ISP)**.¹² If you have received notification that your patient is to be discussed at the Marac, via your Marac point of contact, your GP practice will already be signed up to the ISP. In some circumstances, a governing or commissioning body will have signed the ISP on behalf of GPs collectively.

Sharing information at the Marac does not remove a GP's responsibility to initiate safeguarding procedures where a child or vulnerable adult is at risk.

Section 3: How to record the Marac information safely

Recording information and patient safety

Perpetrators will frequently know that the police are aware of the domestic abuse; this may be because there has been a police call out, for example. **But they will NOT know that their case is being discussed at the Marac.** In some cases heard at the Marac, **the perpetrator will NOT know that the patient has disclosed domestic abuse at all.** This may be because there has not been a police call out and a different agency working with the victim has referred the case to the Marac. **In these cases, an accidental discovery by the perpetrator would increase the risk of harm to the patient and their child(ren).** Therefore, the GP should:

- **Never disclose any allegation to the perpetrator** or any other family members (there is a risk of family members colluding with the perpetrator, multiple perpetrators within the family, or where there is the risk of 'honour'- based abuse).
- Ensure that any reference to domestic abuse or the Marac on a victim's or their child(ren)'s records is **not accidentally visible to the perpetrator** during appointments. The computer screen showing the medical record should never be seen by third parties (i.e. family or friends accompanying a patient).
- Ensure that any reference to domestic abuse or Marac in a perpetrator's record is **redacted if information is provided to the perpetrator**, (please see below for further guidance from the Information Commissioner's Office).
- Ensure that any reference to domestic abuse or the Marac is **redacted from the child(ren)'s records** if provided to the perpetrator or to any child(ren) deemed to have capacity to request their own information (see Information Commissioners Office guidance).
- Ensure that any decision to record the information in the perpetrator's notes is made with due regard to the **associated risks**, and documented (please see the below text box 'Should I record information in the perpetrator's records?').

¹¹ See 'Striking the balance' – applying Caldicott principles to the MARAC process':

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215064/dh_133594.pdf; and the updated principles with added principle about the duty of sharing information (see page 21):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf

¹² See Information Sharing Protocol checklist: <http://www.safelives.org.uk/node/352>. See also Caldicott principles:

<http://systems.digital.nhs.uk/infogov/igfaqs/quickreferencecf.doc>

Be aware of the potential danger of the perpetrator having access to information about their abuse and information included in children's files; this includes through **online access** to their own information and their child(ren)'s information, as well as via the victim's records.¹³

Should I record information in the perpetrator's record?

Where a GP is **certain** that the perpetrator is aware that domestic abuse has been disclosed to the police or other agency, relevant information regarding domestic abuse or the Marac should be recorded in the perpetrator's record.

Where the GP is **not certain** that the perpetrator is aware of any allegation (or disclosure), the GP should not record information on the perpetrator's record.

*It is unlikely that the GP will be **certain** of the extent of the perpetrators knowledge of domestic abuse disclosures or allegations to other agencies. Therefore, in most circumstances, the GP will not record information within the perpetrator's notes.

Section 4: Sharing information with the perpetrator

Never share any information from the Marac with the perpetrator. Please note that perpetrators are **NOT** informed when a victim is referred to the Marac, so it is unlikely that they will be aware of this information already.

The risks associated with sharing this information also needs to be considered in case the perpetrator makes a subject access requests (SAR) (i.e. a request made by an individual for their personal information) for their medical records. According to the Information Commissioners Office (ICO), where a patient's record contains information regarding another individual or you believe that sharing that information could present a risk to another individual (i.e. the victim or the child(ren) you do not have to comply with the SAR and may redact any information regarding another individual.¹ For more information regarding subject access requests (SAR) see the ICO's guidance on SARs, particularly the section: What should I do if the data includes information about other people?. Also refer to the Royal College of General Practitioners guidance, in particular section 6.2.2 regarding the risk of coercion.¹⁴

If a victim requests this information on behalf of the perpetrator (or consents to the perpetrator seeing their information) you must consider potential coercion by the perpetrator to do so, and whether sharing this information, could present a risk to the victim or any child(ren).

Visit safelives.org.uk/gp for more information and accompanying resources

¹³ See elearning.rcgp.org.uk/pluginfile.php/74124/mod_folder/content/0/PatientOnline-Coercion-guidance.pdf?forcedownload=1

¹⁴ <http://www.rcgp.org.uk/-/media/Files/Informatics/Health-Informatics-Enabling-Patient-Access.ashx?la=en>
Information Commissioner's Office: Guidance for responding to subject access requests. <https://ico.org.uk/for-organisations/guide-to-data-protection/principle-6-rights/subject-access-request/> Accessed on 01 June 2016/

