University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY & PROCEDURES REGARDING DOMESTIC VIOLENCE AND ABUSE

Reference Number **CL-RM/2014/042**	**Version: 1.5**		**Status** **Final**	**Author: Jane O'Daly-Miller** **Job Title: Head of Safeguarding & Vulnerable People**
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	1	June 2012	Jane O'Daly	Ensure Compliance with Safeguarding Children Statutory Guidance, LSCB procedures, DoH Guidance (2005) and Safeguarding Vulnerable Adults Guidance and Local SAB procedures
	1.1	February 2014	Mary Driver	Incorporate new definition of Domestic Violence and (Draft) NICE Guidance and ensure compliance with MARAC procedures
	1.2	June 2014	Mary Driver	Minor Amendments
	1.3	May 2016	Jane O'Daly-Miller	Review Ensure compliance with DoH Care Act Guidance (2014)
	1.4	December 2018	Jane O'Daly-Miller	Following merger *(Extension agreed until February 2024)*
	1.5	May 2023	Jane O'Daly-Miller	Review
Intended Recipients: All Staff				
Training and Dissemination: Training is by eLearning / face to face sessions advertised on the intranet.				
Linked Policies: Managing Allegations policy (where staff are involved as either victim of perpetrator) Safeguarding Children Policy and Safeguarding Adult Policies				
EIRA stage One Completed Yes stage Two Completed No				
Approving Body and Date of Approval			Trust Delivery Group - January 2019 Minor amendments approved by Executive Lead - 29 November 2023	
Review Date and Frequency			June 2026 (Every 3 years)	
Contact for Review			Head of Safeguarding & Vulnerable People	
Lead Executive Director Signature			 Garry Marsh, Executive Chief Nurse	

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1 Introduction

Domestic abuse is a high harm, high volume crime that remains largely hidden. The Crime Survey for England and Wales (CSEW)4 for the year ending March 2020 estimated that 2.3 million adults aged 16 to 74 had experienced domestic abuse in the previous year. Childhood Local Data on Risks and Needs estimated that, between 2019 and 2020, approximately 1 in 15 children under the age of 17 live in households where a parent is a victim of domestic abuse. The police recorded over 1.5 million domestic abuse related incidents and crimes in England and Wales in the year ending March 2021. This is an increase of 6% from the previous year and the national findings are mirrored in the Derbyshire Police Service.

Domestic abuse is cruel and complex, and can affect anyone, leaving physical and emotional scars that can last a lifetime. Anyone can be affected by domestic abuse – regardless of age, disability, sex, sexual orientation, gender identity, gender reassignment, race, religion, or belief. In addition, domestic abuse can manifest itself in different ways within different communities.

Many domestic homicide victims are women. Data for the period March 2018 to 2020 showed that 276 women were victims of domestic homicide and in 97% of cases the suspect was male. Over the same period, 86 men were killed in domestic homicides. In 62% of the cases the suspected perpetrator of these homicides was male, and in 38% of the cases the suspect was female.

Whatever form it takes, domestic abuse is rarely a one-off incident, and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over their victim. Typically, the abuse involves a pattern of abusive and controlling behaviour, which tends to get worse over time. The abuse can begin at any time, often begins in pregnancy, in the first year, or after many years of life together. It may begin, continue, or escalate after a couple have separated and may take place not only in the home but also in a public place.

Domestic abuse occurs across society, regardless of age, gender, race, sexuality, wealth, and geography. The figures show, however, that it consists mainly of violence by men against women. Children are also affected, both directly and indirectly and there is also a strong correlation between domestic violence and child abuse suggesting overlap rates of between 40-60%. All children living in households where domestic violence and abuse is happening suffer emotional harm and may be subject to violence themselves. Research has shown that some teenagers have worryingly high levels of acceptance of domestic violence and abuse within their own relationships.

It is generally committed in private and behind closed doors and, as such, is under recorded and underreported; but it is far from being a private issue. It is a significant health issue and impacts on the emotional, physical, and psychological well-being of the person being abused and those living with them. Although both men and women may perpetrate or experience domestic violence and this policy is equally applicable to either, it is more commonly inflicted on women by men. This is particularly true for severe and repeated violence and for sexual violence.

Research shows that health care professionals are one of the few groups that perpetrators of domestic violence or abuse may disclose to, and thus staff may have the potential to influence the situation and provide an opportunity to plan for safety of the victim. Whilst it is recognised that no single agency can effectively tackle these issues alone, the Health Service has a critical role to play in responding to victims and all staff should be aware of and contribute towards creating an

environment that supports people who suffer violence and abuse at home to get the help that they need.

The Trust has a **zero-tolerance** position on domestic violence and abuse and is committed to establishing a workplace culture that recognises that the responsibility for it lies with the perpetrator and allows those experiencing domestic violence or abuse to make disclosures without fear of judgement and stereotyping.

Under the Health and Safety at Work Act (1974) and the Management of Health and Safety at Work Regulations (1992), the Trust recognises its legal responsibilities in promoting the welfare and safety of all staff. Furthermore, any employee of the Trust who is experiencing domestic violence or abuse has the right to raise the issue with their employer in the knowledge that they will receive the appropriate support and assistance. This policy also covers the approach to be taken when there are concerns that an employee may be the perpetrator of domestic violence or abuse and this policy is part of the Trust commitment to family friendly working and seeks to benefit the welfare and safety of individual members of staff, retain valued employees, improve morale and performance, and enhance the reputation of the Trust as an employer of choice.

This policy applies to all staff across all sites.

2 Purpose

This policy aims to:

- Clarify the roles and responsibilities of the Safeguarding Team, Senior Managers, Line Managers, and all Trust staff in responding to domestic violence and abuse.
- Provide clear direction that reflects national guidance, including the Trust's obligations under the Care Act (2014), The Domestic Abuse Act 2021 and Domestic Abuse Statutory Guidance 2022 (Home Office) and contributes to the multi-agency effort to tackle domestic and violence and abuse.
- Ensure continued interagency working through the identification of clear channels of referral, communication, and networking.
- Assist staff in identifying those experiencing domestic violence and abuse, including supporting staff to create a safe environment to encourage disclosures.
- Assist staff in their decision making to optimise the safety of those who have experienced domestic violence and abuse, and their dependents.
- Enable staff to respond in a consistent and comprehensive way, ensuring the services delivered are fair, effective and of a high standard.
- Ensure that the welfare of adults at risk and children & young people is paramount.
- Identify issues as they relate to employees who may be victims or perpetrators of domestic violence.

3 Definitions

Domestic Abuse	Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—(a) A and B are each aged 16 or over and are "personally connected" to each other, and (b) the behaviour is abusive. **Behaviours are "abusive" if it consists of any of the following**— (a) physical or sexual abuse; (b) violent or threatening behaviour; (c) controlling or coercive behaviour; (d) economic abuse (any behaviour that has a substantial adverse effect on B's ability to —(a) acquire, use or maintain money or other property, or (b) obtain goods or services.) (e) psychological, emotional, or other abuse (and it does not matter whether the behaviour consists of a single incident or a course of conduct.) (A's behaviour may be behaviour "towards" B, even though it consists of conduct directed at another person (for example, B's child)). **Two people are "personally connected" to each other if** any of the following applies — (a) they are, or have been, married to each other; (b) they are, or have been, civil partners of each other; (c) they have agreed to marry one another (whether or not the agreement has been terminated); (d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated); (e) they are, or have been, in an intimate personal relationship with each other; (f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (g) they are relatives. A person has a parental relationship in relation to a child if — (a) the person is a parent of the child, or;

	(b) the person has parental responsibility for the child. **"Child" means a person under the age of 18 years.** Children as victims of domestic abuse are child / children who (a) sees or hears, or experiences the effect of, the abuse, and (b) is related to A or B.
Controlling or coercive behaviour	Applicable where: The victim and perpetrator are "personally connected" at the time the behaviour takes place, and the behaviour has had a serious effect on the victim, meaning that it has caused the victim to fear violence will be used against them on two or more occasions, or it has had a substantial adverse effect on the victim's usual day to day activities; and the behaviour takes place repeatedly or continuously. The perpetrator must have known that their behaviour would have a serious effect on the victim, or the behaviour must have been such that he or she ought to have known it would have that effect. The following examples are within the range of behaviours that might be considered controlling or coercive behaviour. This list is not exhaustive: • Controlling or monitoring the victim's daily activities and behaviour, including making them account for their time, dictating what they can wear, what and when they can eat, when and where they may sleep; • Controlling a victim's access to finances, including monitoring their accounts or coercing them into sharing their passwords to bank accounts to facilitate economic abuse; • Isolating the victim from family, friends and professionals who may be trying to support them, intercepting messages, or phone calls; • Refusing to interpret and/or hindering access to communication; • Preventing the victim from taking medication, or accessing medical equipment and assistive aids, over-medicating them, or preventing the victim from accessing health or social care (especially relevant for disabled victims or those with long-term health conditions);

	• Using substances to control a victim through dependency, or controlling their access to substances; • Using children to control the victim, e.g., threatening to take the children away; • Using animals to control or coerce a victim, e.g., harming or threatening to harm, or give away, pets or assistance dogs; • Threats to expose sensitive information (e.g., sexual activity or sexual orientation) or make false allegations to family members, religious or local community including via photos or the internet; • Intimidation and threats of disclosure of sexual orientation and/or gender identity to family, friends, work colleagues, community, and others; • Intimidation and threats of disclosure of health status or an impairment to family, friends, work colleagues and wider community – particularly where this may carry a stigma in the community; • Preventing the victim from learning a language or making friends outside of their ethnic or cultural background; • Threatening precarious immigration status against the victim, withholding documents, giving false information to a victim about their visa or visa application, e.g. using immigration law to threaten the victim with potential deportation; • Using the victim's health status to induce fear and restrict their freedom of movement; • Threats of institutionalisation (particularly for disabled or elderly victims); • Physical violence, violent or threatening behaviour, sexual abuse, emotional or psychological abuse, economic abuse and verbal abuse Controlling or coercive behaviour is a pattern of behaviour often perpetrated alongside other forms of abuse. A victim may not be aware of the abusive behaviours or be prepared to make a disclosure. In supporting victims to address controlling or coercive behaviour, agencies should consider the cumulative impact of a perpetrator's behaviours (including those that may seem harmless) and the pattern of behaviour within the context of the relationship. Controlling or coercive behaviour should be dealt with as part of safeguarding and public protection procedures. Professionals should be aware of the impact of this behaviour on victims, including children and young people.
Economic abuse	Economic abuse refers to behaviour that has a substantial adverse effect on an individual's ability to acquire, use or maintain money or other property, or to obtain goods or services. This can include an individual's ability to acquire food or clothes, or access transportation or utilities.

	These behaviours can include an attempt to control thro Examples of economic abuse might include the following: • Controlling the family income; • Not allowing a victim to earn or spend any money unless 'permitted'; • Denying the victim food or only allowing them to eat a particular type of food; • Running up bills and debts such as credit or store cards in a victim's name, including without them knowing; • Refusing to contribute to household income or costs; • Deliberately forcing a victim to go to the family courts so they incur additional legal fees; • Interfering with or preventing a victim from regularising their immigration status so that they are economically dependent on the perpetrator; • Preventing a victim from claiming welfare benefits, or forcing someone to commit benefit fraud or misappropriating such benefits; • Interfering with a victim's education, training, employment, and career so that they are economically dependent on the perpetrator; • Not allowing a victim access to mobile phone/car/utilities; • Damaging the victim's property; • Not allowing a victim to buy pet food or access veterinary care for their pet; • Coercing the victim into signing over property or assets; • Refusing to make agreed or required payments, for example mortgage repayments or child maintenance payments; and • Deliberately frustrating the sale of shared assets, or the closure of joint accounts or mortgage restriction, exploitation and/or sabotage
Technology facilitated abuse	Perpetrators can use technology, including social media to abuse victims. This can happen during and after the relationship. Some examples of technology-facilitated abuse include: • Placing false or malicious information about a victim on their or others' social media; • Setting up false social media accounts in the name of the victim; • 'Trolling' with abusive, offensive, or deliberately provocative messages via social media platforms or online forums; • Image-based abuse – for example, the creation of false/digitally altered images and the non-consensual distribution, or threat thereof, of private sexual photographs and films with the intent to cause the person depicted distress ('revenge porn'); • "Up skirting' which involves someone taking a picture under

	another person's clothing without their knowledge; • Hacking into, monitoring or controlling email accounts, social media profiles and phone calls; • Blocking the victim from using their online accounts, responding in the victim's place, or creating false online accounts; • Use of spyware or GPS locators on items such as phones, computers, wearable technology, cars, motorbikes, and pets; • Hacking internet enabled devices such as PlayStations or iPads to gain access to accounts or trace information such as a person's location; • Using personal devices such as smart watches or smart home devices (such as Amazon Alexa, Google Home Hubs, etc) to monitor, control or frighten; and Use of hidden camera
Emotional or psychological abuse	Domestic abuse often involves emotional or psychological abuse. Some of these behaviours will also be controlling or coercive behaviour. Emotional or psychological abuse can include: • Manipulating a person's anxieties or beliefs or abusing a position of trust; • Hostile behaviours or silent treatment as part of a pattern of behaviour to make the victim feel fearful; • Being insulted, including in front of others. This includes insulting someone about their race, sex or gender identity, gender reassignment, sexual orientation, disability, age, faith, or belief or undermining an individual's ability to parent or ability to work; • Repeatedly being belittled; • Keeping a victim awake/preventing them from sleeping; • Using violence or threats towards assistance dogs and pets to intimidate the victim and cause distress, including threatening to harm the animal as well as controlling how the owner can care for the animal; • Threatening to harm third parties (for example family, friends, or colleagues); • Using social media sites to intimidate the victim; and • Persuading a victim to doubt their own sanity or mind (including 'gaslighting'). • Repeated yelling and shouting; • Abusive, insulting, threatening, or degrading language; • Verbal humiliation either in private or in company; • Being laughed at and being made fun of; and • Discriminating against someone or mocking them about their disability, sex or gender identity, gender reassignment, religion or faith belief, sexual orientation, age, physical appearance etc
Intimate Partner Abuse	Domestic abuse most commonly takes place in intimate partner relationships, including same sex relationships. Intimate relationships can take different forms, partners do not need to be married or in a civil partnership and abuse can occur between non-cohabiting intimate

	partners. As with all forms of abuse, abuse in intimate relationships can vary in severity and frequency, ranging from a one-off occurrence to a continued pattern of behaviour. Abuse can continue or intensify when a relationship has ended or is in the process of ending. This can be a very dangerous time for a victim including an increased risk to their physical safety. It is a highly critical period for ensuring support for victims, as they may consider returning to perpetrators during the period immediately after fleeing or ending the relationship. Separation can raise both the likelihood and consequences of risk because of the perpetrator's perceived lack of control. It may be facilitated by technology and without effective intervention it can be ongoing and may escalate.
Teenage relationship abuse	Young people can experience domestic abuse within their relationships. Teenagers may not self-identify as victims. They may perceive their relationships to be 'casual', for example engaging in multiple romantic and sexual partners through dating apps. Those who engage in abusive behaviour may seek to minimise or deny the abuse by stating that they were not in a relationship. Teenage relationship abuse is not a term that is defined by the 2021 Act, or elsewhere in law. However, if the victim and perpetrator are at least 16 years old, abuse in their relationship can fall under the statutory definition of domestic abuse. Whilst young people under the age of 16 can experience abuse in a relationship, it would be considered child abuse as a matter of law. Abusive behaviours by one young person toward another, where each are aged between 16 and 18 could be both child abuse and domestic abuse as a matter of law. Ultimately, in responding to cases of abuse involving those under 18, child safeguarding procedures should be followed. Abusive behaviours within relationships between young people can include similar incidents or patterns of behaviours as adult relationships. For teenagers in particular, abuse to harass or control victims can occur through using technology, this includes social media, or location-based tracking apps, such as Find My Friends. Young people's lives are often heavily online-based and perpetrators of abuse may exploit this, demanding access to passwords and monitoring online activity. Young people may also experience intimate image abuse within their relationships, including threats to expose intimate images.

	Teenage relationship abuse often occurs outside of a domestic setting. Victims may feel that domestic abuse occurs only between adults who are cohabiting or married. Teenage victims may find it difficult to identify abusive behaviour, for instance, controlling or jealous behaviour may be misconstrued as love. Domestic abuse in teenage relationships can be just as severe and has the potential to be as life threatening as abuse in adult relationships. Young people who experience domestic abuse do so at a particularly vulnerable point in their lives. They may experience a complex transition from childhood to adulthood which impacts on behaviour and decision making. It may impact on the way that they respond to abuse or if and how they engage with services. Due to the stigma attached to LGBT (Lesbian, Gay, Bisexual and Trans) identities, young people from the LGBT community may lack relevant and accurate information on healthy relationships, which may inform behaviour and decision making. LGBT young people may face unique obstacles to seeking help, especially in a context of a first relationship or when first coming out as they may be unable to confide in their peers or family, owing to the reaction they might receive due to their sexuality or gender identity.
Abuse by family members	Domestic abuse may also be perpetrated by a family member: by children, grandchildren, parents, those with "parental responsibility", siblings, or extended families including in-laws. Abuse may be perpetrated towards a victim by more than one relative. Abuse within a family set up can encompass several different harmful behaviours. Abuse may be perpetrated as a perceived means to protect or defend the 'honour' of an individual, family or community against alleged or perceived breaches of the family or community's code of behaviour. It can therefore include 'honour'-based abuse, forced marriage, female genital mutilation, and other harmful practices such as reproductive coercion (and as part of this, forced abortion). In responding to abuse by family members, services should consider the ways in which the patterns of abuse may differ from, or in cases relate to, patterns of abuse found in cases of intimate partner abuse. Services should ensure assessment procedures are used appropriately to identify risk. For example, professionals should be aware that family members are not always protective figures for those who experience intimate partner abuse, as in some circumstances family members may constitute a risk themselves and be complicit in abuse.

Child-to-parent abuse	Abuse within the family includes child-to-parent abuse, also commonly referred to as Adolescent to Parent Violence/Abuse (APV/A) and Child and Adolescent to Parental Violence and Abuse (CAPVA). Child-to-parent abuse can involve children of all ages, including adult children, and abuse toward siblings, grandparents, aunts, uncles as well as other family members such as those acting as kinship carers. If the child is 16 years of age or over, the abuse falls under the statutory definition of domestic abuse in the 2021 Act. There is no specific legal definition of child-to-parent abuse but it is generally accepted to involve some of the patterns of behaviour that can be found in other relationship contexts. Behaviours can encompass, but are not limited to, humiliating and belittling language, violence and threats, jealous and controlling behaviours, damage to property, stealing and heightened sexualised behaviours. Child-to-parent abuse appears gendered, with many cases being perpetrated by sons against their mothers, although men and boys are victims too. Like other forms of abuse, child-to-parent abuse is characterised by shame and stigma which could mean parents are less likely to report the abuse to the police. Parents may fear being blamed, disbelieved, or conversely having their child taken away from them or criminalised leaving them reluctant to seek help. Recorded incidents likely represent only a small number of real cases as families facing crisis point make the difficult decision to disclose their abuse. Victims of this type of abuse should also receive appropriate domestic abuse response and support.
Physical Abuse	Physical abuse and violent or threatening behaviour can involve but is not limited to: • Being, or threatened to be, kicked, punched, pinched, pushed, dragged, shoved, slapped, scratched, strangled, spat on, and bitten; • Use, or threats of use, of weapons including knives and irons; • Being, or threatened to be, burned, scalded, poisoned, or drowned; • Objects being thrown at or in the direction of the victim; • Violence, or threats of physical abuse or violence, against family members; • Causing harm by damaging or denying access to medical aids or equipment –for example a deaf person may be prevented from communicating in sign language or may have their hearing aids removed; and • Harming someone whilst performing 'caring' duties, which are often performed by relatives. This is especially relevant for individuals who are heavily dependent on others, such as

	disabled and older people and may involve force feeding, over-medication, withdrawal of medicine or denying access to medical care. The Serious Crime Act 2015 creates an offence of non-fatal strangulation. Non-fatal strangulation can be used as a form of assault in domestic abuse and a history of strangulation can increase the risk of an eventual fatality. Visible marks are not always present; the absence of marks should not undermine an account of non-fatal strangulation. Non-fatal strangulation is often used to instil fear and exert power and control. Victims who experience non-fatal strangulation may believe at the time that they will die as a result. Loss of consciousness, even temporary, can cause brain damage, this includes long-term neurological damage such as memory loss and facial droop. In addition, loss of consciousness can create an increased risk of miscarriage and stroke.
Sexual Abuse	Victims of domestic abuse may experience behaviour that is sexually abusive. This abuse can involve: Rape and sexual assaults; • Being pressured into sex, or sexual acts, including with other people; • Being forced to take part in sexual acts because of threats to others, including children; • Unwanted sexual contact or demands; • 'Corrective' rape (the practice of raping someone with the aim of 'curing' them of being LGBT); • Intentional exposure to HIV (human immunodeficiency virus) or sexually transmitted infections; • Being pressurised or being tricked into having unsafe sex, including deception over the use of birth control; • Forced involvement in making or watching pornography; and • Hurting a victim during sex including non-fatal strangulation Sexual abuse can coexist with sexual exploitation. Forced sex acts may involve; • activities such as being forced to perform pornography or to strip in person, via • webcam or live streaming platform. Perpetrators may force or coerce a victim into • exchanging sex for drugs, alcohol, or money, or coerce them into committing a crime,

- such as theft, to pay, for example, for the perpetrator's drugs or alcohol.

"Rough sex", including sadomasochistic activity, can involve the infliction of pain or violence, simulated or otherwise with the aim of providing sexual gratification for the parties involved. This type of activity can encompass a wide range of behaviours. Although it may occur in private and be consensual, section 71 of the 2021 Act, which states that the infliction of serious harm resulting in actual bodily harm (ABH) or other more serious injury31, means that the person responsible for those injuries will be liable to a criminal prosecution, irrespective of whether consent had been given by the person in receipt of the injuries or not. The matter of consent may be challenging, as victims of domestic abuse may be unable to recognise where they have been coerced into providing consent.

Non-consensual or harmful non-fatal strangulation can arise in a sexual context. Section 70 of the 2021 Act makes a change to the Serious Crime Act 2015 to provide that a person commits the offence of strangulation or suffocation if they intentionally strangle another person or do any other act that affects another person's ability to breathe. These actions constitute battery. Whilst it is a defence for the person accused to show that the other person consented, this does not apply where that other person suffers serious harm because of the strangulation or any other act, and the person accused intended to cause that other person harm or were reckless as to whether that other person would suffer serious harm.

Victims of domestic abuse can also be the subject of reproductive coercion, which can involve:

- restricting a partner's access to birth control;
- refusing to use a birth control method;
- deception regarding the use of birth control including falsely claiming to be using contraception; and
- forcing a partner to get an abortion, IVF or other related procedure; or denying access to such procedures.
- Reproductive coercion can take less overt forms – for instance, a perpetrator may not actively force the victim to have an abortion, but the general cycle of abuse may leave her feeling she has no choice. Women from ethnic minority groups may be more likely to experience reproductive coercion, including forced abortion for 'honour'-based reasons.

FGM	Female Genital Mutilation includes procedures that intentionally alter or injure female genital organs for non-medical reasons. It is mostly carried out on young girls and is illegal in the UK. FGM is a form of violence against women and girls which is both a cause and consequence of gender inequality. It typically occurs within the context of 'honour' based abuse. As FGM is generally inflicted upon children, this is a type of child abuse. However, it is also carried out on women for a variety of reasons such as giving a woman social acceptance before marriage or ensuring her chastity. Whilst FGM may be an isolated incident of abuse within a family, it can be associated with other behaviours that discriminate against, limit or harm women and girls. These may include other forms of 'honour'-based abuse and domestic abuse.
Forced Marriage	A marriage that happens without the full and free consent of both parties. Force includes physical force, being emotionally pressured, being threatened and being a victim of psychological abuse. Forced marriage is an offence under section 121 of the Anti-social Behaviour, Crime and Policing Act 2014 ('the 2014 Act'). Forced marriage typically occurs in the context of 'honour'-based abuse, and involves the use of violence, threats, or any other form of coercion against a person with the intention or belief that the conduct may cause a person to enter a marriage without consent. This includes non-binding traditional, or unofficial marriages. Forced marriage is recognised as a form of domestic abuse - if carried out by someone with a personal connection to the victim and where both parties are at least 16 years old. Usually someone must use violence, threats, or another form of coercion to carry out the offence of forced marriage. However, if a person is unable to consent to marry, under the Mental Capacity Act 2005, any conduct aimed at causing them to marry may be forced marriage, even if it is not violence, threats, or another form of coercion. In all cases, forcing someone into marriage could include making arrangements; the offence could be considered to have occurred even where the marriage does not end up taking place. Victims of forced marriage can be of any age, and many are under 18. Young victims may for example be coerced to marry under the threat of physical violence or the fear of dishonouring their families. (The Government's Forced Marriage Unit can provide advice and support to individuals who are at risk of, or who have experienced,

	forced marriage, and to the professionals and others seeking to help them. Guidance on forced marriage is published on GOV.UK.)
"Honour"-Based Violence	Honour-based abuse is a crime or incident which has or may have been committed to protect or defend the perceived honour of the family and/or community, or in response to individuals trying to break away from constraining 'norms' of behaviour that their family or community is trying to impose. Honour-based abuse can include physical, emotional, or psychological abuse and occur in specific contexts, not all of which represent domestic abuse under the 2021 Act, for example in cases where the victim and perpetrator are not "personally connected". However, honour-based abuse is typically carried out by a member or members of the family or extended family and is likely to involve behaviours specified in the statutory definition of domestic abuse in the 2021 Act. Perpetrators may use a range of tactics against the victim, this can include restrictions to their freedom, isolation, physical abuse, and threats to kill and murder.
Serious Sexual Violence	This includes rape; assault by penetration; inducement, threat, or deception to procure sexual activity with a person with a mental impairment (involving penetrative activity and incest)
Harassment or Stalking	Where harassment or stalking occurs, and the perpetrator and victim are 16 or over and "personally connected", this behaviour falls within the scope of the statutory definition of domestic abuse in the 2021 Act. For example, it may constitute physical abuse, threatening behaviour, controlling or coercive behaviour, or emotional or psychological abuse. There is no statutory definition of harassment but it includes repeated attempts to impose unwanted communications and contact upon a victim, in a manner that could be expected to cause distress or fear. It is generally acknowledged that harassment involves behaviour that is intended to cause a person alarm or distress or to cause them to fear violence when the perpetrator knows or ought to know that their conduct amounts to harassment. Where there is evidence to show that such conduct has occurred on more than one occasion, the perpetrator could be prosecuted under the Protection from Harassment Act 1997 ('the 1997 Act'). The perpetrator's behaviour may follow a pattern, such as sending messages which the recipient finds alarming or distressing, or which causes them to fear violence. Alternatively, the perpetrator's behaviour may differ on each occasion, for example they could use a variety of

	means to harass the victim such as sending threatening messages (for example via text or social media) or emails, making abusive phone calls, damaging property, or falsely reporting a person to the police when they have done nothing wrong. Similarly, there is no statutory definition of stalking. Examples of the type of behaviour considered circumstances to be acts, or omissions, associated with stalking are set out below. This list is not exhaustive, nor does the offence require a personal connection, which means it is wider than, and differs from, domestic abuse: • Following a person; • Contacting, or attempting to contact, a person by any means; • Publishing any statement or other material relating or purporting to relate to a person, or purporting to originate from a person; • Monitoring the use by a person of the internet, email, or any other form of electronic communication; • Loitering in any place (whether public or private); • Interfering with any property in the possession of a person; and • Watching or spying on a person. The police and the Crown Prosecution Service (CPS) have also adopted the following description, which appears in the statutory guidance on Stalking Protection Orders, issued under the Stalking Protection Act 2019: "stalking is a pattern of unwanted, fixated, and obsessive behaviour which is intrusive. It can include harassment that amounts to stalking or stalking that causes fear of violence or serious alarm or distress to the victim." Stalking behaviours may vary but are often motivated by obsession and their behaviour shares a consistent set of characteristics involving fixated, obsessive, unwanted and/or repeated behaviours, online and/or offline. Victims of domestic abuse may be vulnerable to stalkers, particularly when a relationship has ended.
Perpetrator	A person who abuses another person. Some perpetrators do not recognise that their behaviour constitutes domestic abuse, however, all perpetrators are responsible for their behaviour and should be held accountable for it.
Disclosure	When a person reveals that they are experiencing domestic violence and abuse.

Safe Lives Risk Assessment (this may also be known as CAADA-DASH)	This is a risk assessment checklist that enables professionals trained in its use to identify risk to the adult experiencing domestic violence and abuse and offer appropriate resources and support.
IDVA / ISVA	This stands for "Independent Domestic Violence Advisor" or "Independent Sexual Violence Advisor" and refers to a worker who has received specialist training in supporting and advising those who have experienced domestic and/or sexual violence and abuse on how to keep safe, from the point of crisis onwards.
Refuge	A safe house that offers temporary accommodation for mainly women and their children. All refuge addresses and most telephone numbers are confidential so that it is difficult for the perpetrator to find, but you can access refuge accommodation through the Domestic Violence helpline, the Citizen's Advice Bureau, Housing Departments, or the Police.
SARC	This stands for "Sexual Assault Referral Centre" and is a specialist 24/7 service for people who have been raped or sexually assaulted.
Routine Enquiry	Asking all patients direct questions in relation to whether they are experiencing domestic violence or abuse.
Targeted Enquiry	Asking direct or indirect questions to those patients about whom there is a suspicion of domestic violence or abuse.
Serious Harm	Harm that is life-threatening or traumatic, from which psychological or physical recovery is expected to be difficult or impossible.
MARAC	This stands for "Multi-Agency Risk Assessment Conference" and is a meeting that is held across Derby, Derbyshire, and Staffordshire in various localities. Following identification of high-risk cases a referral can be made to the MARAC covering the area where the patient is usually resident in order to provide structured and appropriate professional support that minimises the risk of harm.
Adult at Risk	This describes a person for whom the statutory safeguarding duties apply under the Care Act (2014) and includes an adult who: • has needs for care and support (whether the local authority is meeting those needs) and; • is experiencing, or at risk of, abuse or neglect; and • because of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Child Protection Concerns	Suspicion that a child is at risk of, or has experienced, significant harm, neglect, or abuse.
Children and Young People	A child or young person is anyone who has not yet reached their 18th Birthday or 21yrs if in Local Authority Care (LAC) or 25 if they are disabled. Issues of neglect as defined in Working Together 2010 can apply to the unborn baby Defined in the Children Acts (1989 and 2004).
SCP	Safeguarding Children Partnership
SAB	Safeguarding Adult Boards
CSC	Children's social care
ASC	Adult social care

4 Responsibilities/ Duties

Safeguarding Adult Boards and Safeguarding Children's Partnerships(Staffordshire, Derbyshire and Derby City Local Authorities)	Safeguarding Adult / Children's Partnerships (SAB/SCP) are required to lead adult / Children's safeguarding arrangements across their locality and monitor and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The Trust is required, as a partner agency, to attend the Boards and their sub-groups; participate in the work of the Boards to achieve their aims and submit the findings of the Safeguarding Adult Assurance Framework (SAAF), Markers of Good Practice or s11 (Children Act 2004) audits to the relevant forum at the SAB/ SCB
Integrated Care Boards	The ICB monitor Trust safeguarding performance in regular meetings with the Trust. The Designated Safeguarding Professionals situated within the ICB receive regular reporting on Trust performance, and provide supervision to the Named Nurses, Named Midwives.
Executive Chief Nurse	The Executive Lead for Safeguarding In UHDB and is accountable to the Trust Board for ensuring compliance with this policy in all parts of the Trust. The Executive Lead, or their nominated deputy, is also a member of the SAB/SCP.
Director or People's Services and Trust Designated Officer	The Director of People Services is responsible for ensuring that there are effective arrangements in place for People Services to respond to allegations against Trust staff, including the operation of the role of Trust Designated Officer (DO) who will take the lead for liaison within the Division with the Head of Safeguarding in relation to allegations against staff concerning children, young people, or adults at risk of abuse or neglect. The purpose of the role of DO, working with the Head of Safeguarding & Vulnerable People Team and People's Services Managers, is to • receive information regarding safeguarding concerns and allegations about employees

	• to lead in liaison with the Head of Safeguarding and the relevant LADO or PIPOT Managers in the Local Authority • to oversee, advise and coordinate management teams in relation to Trust response to the subject of the allegation • to ensure that the Trust is compliant with all safe recruitment practices • to attend the Trust Safeguarding Group and provide reports on activity in this area • to ensure effective monitoring and performance regarding, where appropriate, individuals being referred to the respective professional body and the Disclosure and Barring Service
The Head of Safeguarding & Vulnerable People Team	The Head of Safeguarding & Vulnerable People is responsible for safeguarding advice to managers, Patient Advice & Liaison / Complaints team, the Responsible Officer Forum and the Trust DO and also to ensure sufficient training and advice / guidance is in place regarding domestic abuse practice.
Trust Safeguarding Team	The Trust Safeguarding Team is responsible for providing advice to Trust staff, for facilitating liaison with the appropriate Local Authority CSC or ASC department / police, provision of training and supervision and for maintaining records of their involvement in cases, the number and nature of alerts raised.
Trust Safeguarding Group (TSG)	The Trust Safeguarding Group has delegated authority to oversee all activities related to safeguarding to ensure safe high-quality care is delivered, whilst ensuring that risks are identified and managed to an acceptable level, and to receive assurance that the Trust is actively working in partnership with relevant strategic multi-agency partnerships for the purpose of safeguarding and promoting the welfare of adults, children, and young people at risk.

Business Units, Ward Sisters/Charge Nurses, Nursing and medical staff, On-call Managers will	Ensure that they and their staff are aware of the policy and processes relating to Domestic violence and abuse and that they undertake mandatory training and any refresher training required. • Escalate concerns and communicate cases of concern to the relevant CSC / ASC department or police and the safeguarding team. • Have a responsibility to respond sensitively to a disclosure of abuse or historical abuse, act in a professional manner and take appropriate action. • Ensure that concerns about individual cases are escalated to the safeguarding team for advice and support.
Frontline Staff	All staff and those in services contracted by the Trust must ensure that the appropriate processes are followed. They must attend compulsory safeguarding training appropriate to their involvement with patients and the public and ensure they are competent and alert to potential indicators of domestic abuse / abuse or neglect in adults or children.

5 Implementation of the Policy and General Principles

The most important factors in identifying domestic violence and abuse are simple awareness of the fact that it may occur, the forms it may take and the impact that it may have. Indicators of domestic abuse and violence can be seen at Appendix 1.

The process for responding to victim's flowchart is at Appendix 2

5.1 Making Enquiries

All Trust Healthcare Professionals (HCPs) should seek to create opportunities to speak to patients without the presence of others to facilitate the opportunity for abuse to be disclosed.

Appropriately qualified professional interpreters should be used where needed to mitigate the risk of reliance on those who may be attending with the victim. HCPs should not be relying on family members or partners for interpretation services when enquiring about domestic abuse; There is a significant risk that people experiencing domestic abuse may be less likely to disclose abuse with someone they know in the room. It may increase the

risk to the victim if they disclose abuse in front of the perpetrator or someone who could share that information with the perpetrator.

HCPs are often the only professionals with an optimal opportunity to speak privately and safely with victims of domestic abuse and therefore should ensure that where possible, only professional, and independent interpreters are used.

Speaking with victims alone can be difficult operationally; For example, speaking with women alone can be difficult within maternity services. Pregnant women may be accompanied by their partners, family members or friends in attending antenatal appointments or making ultrasound scan visits. Whilst this is challenging, seeking to create opportunities for private discussion can be crucial.

Examples of routine and targeted enquiries can be seen at Appendix 3.

If family members are present, it should be stated that in all health appointments there is an expectation that there will be a private time between the patient and HCPs and the family be removed from the bedside and close situation to facilitate enquiry. However if there is no professional interpreter, and one is required, and note should be made as to why the enquiry was not carried out and an interpreter booked for the next appointment. This applies equally to children as they can repeat what they hear, even if they do not understand what it means. It is important, therefore, to facilitate occasions during the patient's attendance when 1:1 contact is possible.

When making any enquiry:

- Remind the patient that anything they choose to disclose will be treated confidentially but be clear about the limitations of this.
- Explain that you have a duty to share information with relevant agencies where a disclosure raises implications for the safety of a child, another person or the individual involved.
- Ensure privacy, and that you cannot be overheard.
- Avoid interruptions and do not rush the person.
- Ask questions in a sensitive manner. This may include beginning with indirect, non-threatening questions and progressing to direct questions (see Appendix 3).
- Listen carefully and openly and question anything that you do not understand as requests for help may be veiled and oblique.
- Ask about any children in the household, or for whom there may be possible safeguarding or child protection concerns.
- If you have concerns, explain them openly to the patient but be aware that they may not disclose abuse even if it is happening. Do not try to force them to do so but continue to offer support.
- If you have concerns, give the patient information about support services regardless of whether a disclosure is made where possible.

If the patient is deaf, or their first language is not English, staff must arrange for a professional interpreter or advocacy worker to be present as soon as possible.

A Language Identification Chart is attached at Appendix 4.

5.1.a Routine Enquiry Regarding Domestic Violence and Abuse, and Recording of Concerns / Disclosures

i. On attendance to the emergency department or MIU a routine enquiry regarding domestic violence and abuse as a risk factor should be made. The routine enquiry should be made when the patient is unaccompanied. A targeted enquiry should be made when Domestic violence / abuse is suspected due to the nature of the injuries and the inconsistency / inappropriateness of explanation.

Documentation
For adults in Derby hospital sites, the routine enquiry and response should be clearly recorded in the triage record noting a positive routine enquiry response (RE+ve) or negative routine enquiry response (RE-ve)

In Burton sites responses should be documented on the v6 record.

ii. On admission to hospital, a routine enquiry regarding domestic violence and abuse as a risk factor should be made.

Documentation
For adults in Derby hospital sites, the routine enquiry and response should be clearly recorded in the Patient Admission Document in the Routine Enquiry box, which asks staff to record a positive (RE+ve) or negative (RE-ve) response.

In Burton sites responses should be documented on the v6 record Patient Admission module

iii. Similarly routine enquiry should be recorded for all children aged 16 or 17 years

Documentation
At Derby Hospital sites, the response should be recorded in the Routine Enquiry box of the Paediatric Admission Document. In addition, for all children domestic violence and abuse can be recorded as an Adult Risk Factor in the Paediatric Admission Assessment by ticking the "DV" box under the heading "Risk Factors" if there are concerns that this is an issue in the family. Concerns should also be documented in the safeguarding section of Lorenzo.

In Burton sites responses should be documented on the v6 record

iv. Maternity services: There is an increased risk of domestic violence and abuse during pregnancy, with pregnant teenagers being particularly vulnerable. For 30% of women who experience domestic violence and abuse, the first incident occurs in pregnancy.
Staff are required to make routine enquiry regarding domestic violence and abuse three times during pregnancy: at least twice antenatally and at least once in the

post-natal period. This must be clearly documented on the Maternity Handheld Record as follows; RE+ve for a disclosure of domestic violence or abuse or RE-ve where none is disclosed. A safeguarding referral for the unborn baby must be made without delay in the case of a positive response. A DASH (previously known as "Safe Lives") risk assessment must be undertaken with any woman reporting a positive response during pregnancy and the case discussed in safeguarding supervision.

Any member of the maternity team who notices that a woman has an injury, for example a bruised eye, should ask sympathetically, but directly, about how this occurred and be prepared to follow up this enquiry with information, advice and support as needed.

In addition to universal responsibilities in relation to information sharing, the midwife is also responsible for sharing a positive disclosure with the GP and Health Visitor. The Named Midwife in the Safeguarding team should additionally be contacted in order that an alert can immediately be placed on their emergency department record.

5.2 Responding to a Disclosure

In all cases, concerns should be clearly documented.

If a patient makes a disclosure Then they must be assessed using the DASH (Safe Lives) risk assessment tool, a safety plan developed with the patient and support offered. Staff should particularly:

- Address any immediate threats to safety.
- Let the person know that they are believed and that it is not their fault.
- Let them know that they are not alone.
- Encourage them to see that they deserve to be safe and there is life after abuse.
- Attend to all their health needs. They may have injuries that need treating or need a referral to social services, mental health, or substance misuse services.
- The Safeguarding team should be contacted for advice and support.

Above all, the priority is to consider their immediate safety and that of any dependants. Staff should complete ASC referrals (where the eligibility criteria is met) and where children / unborn babies are identified CSC referrals need to be made. The police may be contacted either with or, where serious harm is identified, without the patient's consent.

Ward strategies may be required if the perpetrator attends as a visitor, to protect the patient and/or staff, and staff should discuss this with their Line Manager and the Safeguarding Team.

5.2.1 Forensic evidence and specialist support

Referral to the area SARC (See Appendix 5) must be offered in cases of rape or sexual assault. Where the victim is an adult who meets the criteria for a safeguarding referral or a child / young person the process of examination at a SARC will be coordinated by the police and social care - who must be contacted in these circumstances.

If referral is declined, consideration should then be given to

- preserving evidence of any recent violence by retaining clothing and/or bed linen for the patient,
- photographing injuries (requested via medical imaging on the Clinical Photographic Consent Form),
- completing a Body Map (safeguarding intranet)

For adults who do not meet the adult at risk criteria, all of this can be done with or without the initial involvement of the Police and should be offered to give the person making the disclosure the best chance of a successful outcome in either the criminal or civil courts if they decide to seek legal help now, or in the future.

In cases of rape or sexual assault, forensic medical examination should be considered up to 7-10 days after an assault, or referral to the SARC for ongoing counselling and support for those disclosing historic assaults.

5.2.2 DASH Risk Assessment

The outcome of the DASH (Safe Lives) risk assessment should be shared with the individual (ie those identified at high risk should be told that the information suggests significant risk of homicide, and those at medium risk should be told that the risks are of serious harm, to them and their family).

Where it is not specifically indicated on the scoring outcome, referral to MARAC can be still be considered based on professional judgement and such indicators include;

- escalation of violence
- a high level of coercion and control
- attempted strangulation within or outside of sexual activity
- bizarre and sadistic forms of violence or abuse / access to weapons
- threatened use of weapons
- Pregnancy
- Cruelty to children / pets
- Threats to children, young people, or adults in the care of the partner.

The patient must be informed of our concerns that they are at high risk.

Where an adult declines initial screening or referral for on-going support at this time, they must be advised of the services that are available and offered information in a format that is suitable for them.

5.2.3 Documentation

Recording of the patient's responses to an enquiry should be factual but can include the staff member's observations of body language / etc and interpretation of this.

Fact must be clearly distinguished from opinion and the exact terms / wording used by the individual should be recorded wherever possible.

Staff actions, and the justification for them, should be recorded and the accounts must be timed, dated, signed with the member of staff's name and designation clearly printed.

In all cases, staff should try to establish a safe telephone number on which the person can be contacted and give them the National Domestic Violence Helpline in a format that is safe for them to have.

It is recognised that dealing with disclosures of domestic violence and abuse can be traumatic for staff, especially if they have themselves been subject to it. Staff are encouraged to raise any issues they may be having with their Line Manager, or to make a self-referral to the Employee Assistance Programme if needed.

5.2.4 Safety Planning

Safety planning should be routinely completed and can include the following:

- Advise to keep their mobile phone fully always charged and with them.
- Be aware that there are services out there that can help if they do not want to stay at home, or that can help them to make their home more secure (social care or the IDVA team can advise).
- Keep a list of useful phone numbers so that they can get advice when needed.
- Tell someone they trust about the problems they are having so that they can offer support.
- Keep some money and essential items (including important documents) in a safe place. Ask a friend or family member to keep them if necessary.
- Keep a copy of any court orders in a safe place.
- If they have children at school, consider letting the school know about their circumstances.

As a minimum, staff should aim to advise the patient that if they are in immediate danger to telephone 999 to keep themselves and their family safe.

If the patient does not wish to return to, or wishes to leave, their home address staff should facilitate the patient to explore alternative options for accommodation in the interim, by supporting them to contact family or friends, or relevant agencies such as social care, the IDVA team or the National Domestic Violence Help line (See useful information at appendix 5).

If the patient wishes to stay with the perpetrator, it is vital that a safe telephone number is established so that any support agencies involved can make contact, and that they know how to access support if the situation becomes unsafe.

Staff should be mindful that there are complex reasons why a person experiencing domestic violence may choose not to leave the perpetrator and they must respect and accept the patient's decision, **provided the patient has the capacity to make it.** However, any duty to share information must be considered and it is the responsibility of the professional involved at the time of the patient's discharge to ensure that all of the relevant factors have been considered, and relevant advice sought in order to reach agreement concerning:

- What information is to be shared.
- With whom.
- By whom.

5.2.5 Confidentiality and Information Sharing

It is vitally important that information about domestic violence and abuse is kept securely and is shared only with those who need to know. Any information shared must be:

- Accurate.
- up to date.
- necessary for the purpose of protecting someone.
- shared only with those people who need to see it.
- shared securely.

Seeking consent to share information is the preferred practice in relation to patients experiencing domestic violence and abuse and information should only be passed to another agency without the client's consent when there is a risk of significant harm to the person involved, there is a risk or harm to another person or there are child protection issues. Circumstances in which there is a duty to share information to preserve safety include:

- If anyone is in immediate danger, dial 999.
- If there are concerns that an adult does not have capacity to make decisions about their safety, or is an Adult at Risk, contact ASC.
- If there are children in the care of the person experiencing or perpetrating domestic violence or abuse, or if it is a woman who is pregnant, or if the person making the disclosure is aged 16- or 17-years contact must be made with CSC to establish the background and share information regarding the risk to the children or unborn baby.
- If patient is a pregnant woman, a referral to CSC on behalf of the unborn baby. Contact must also be made with the Safeguarding Team.
- If the person themselves is at risk of Serious Harm, or another person is at risk of harm, information about the risk must be shared with other agencies even if it is against the patient's wishes.

Furthermore, if there have been previous legal proceedings, it is important to ascertain if there are any court orders limiting contact with any children or their parent by the perpetrator. If there are, and contact is ongoing, staff must make ensure that this information is also shared with CSC.

Whilst it is recognised that breaches of confidentiality can increase the risk to the person experiencing domestic violence and abuse, and any children, it is also clear that failing to share information appropriately can have the same effect. All decisions about whether to share information will need to be made on a case-by-case basis and will need to balance the risks of information sharing with the potential benefits of enhanced safety and protection that this may bring. Cases such as these must be discussed with the safeguarding team and all decisions must always be clearly recorded.

Where there exists a clear duty to share information it is better to tell the person that this will happen rather than requesting consent and risking a refusal that potentially damages trust. This applies equally where there are concerns but no disclosure. It is always important that the person experiencing domestic violence and abuse is advised of what information will be shared, and with whom, unless there are significant concerns that doing so would increase the risk. Information that may be useful in deciding whether to share information without consent can be found at Appendix 6.

5.2.6 Employee Witnessing Domestic Violence

Occasionally, staff may witness incidents or interactions which are indicative of domestic violence or abuse. Where violence is witnessed, staff must inform the Police on 999 **immediately**. Security should be summoned, and the perpetrator must be asked to leave if still present. All conversations or interactions of concern must be thoroughly documented. All staff are expected to co-operate with Police enquiries and can expect support from their Line Manager, the Safeguarding Team, Legal Services, and the Employee Assistance Programme, as appropriate, in doing so.

5.2.7 Employees Experiencing Domestic Violence - guidance for Line Managers, Occupational Health and others with responsibility for employee health and well-being.

The Trust recognises that domestic violence and abuse is an equalities issue and undertakes not to discriminate against anyone who has been subjected to it both in terms of current employment and future development.

Whilst it is for the individual themselves to recognise that they are experiencing domestic violence and abuse, there are signs which may indicate an employee may be a victim. These may include:

- Open disclosure by the staff member to a colleague.

- Colleagues or Union Representative telling a staff member's manager that s/he is experiencing domestic violence and abuse.
- Obvious effects of physical abuse.
- A drop in performance or a significant change in behaviour.
- A change in attendance, which could be either absences or "presenteeism" (where victims prefer to be at work rather than at home).

It is essential to understand that any of the above may arise from a range of circumstances, of which domestic violence and abuse may be one.

The Trust respects its employees' right to privacy. Whilst the Trust strongly encourages those experiencing domestic violence and abuse to disclose for the safety of themselves and all those in the workplace, it does not force them to share this information if they do not want to. However, a DASH (Safe Lives) risk assessment and safety planning should take place as offered to patients.

The Trust will extend the same standards of confidentiality to any member of staff who discloses that they are suffering from domestic violence and abuse as apply to patients. Employees can be assured that the information they provide will not be shared, including with other members of staff, without their prior knowledge but should be aware that there may be additional circumstances in which the Trust has to breach confidentiality to protect their safety arising from its responsibility to protect patients and all those using Trust premises. The Trust will seek specialist advice before any such decision is made and, if it decides to proceed in breaching confidentiality after having taken advice, it will discuss with the employee why it is doing so, and it will seek the employee's agreement where possible.

Where domestic violence and abuse in a same sex relationship is disclosed, due regard will be paid to the double disclosure of confidential information: particularly where the individual recipient of abuse may not be open about their sexuality at work.

Information will only be shared on a need-to-know basis and all records concerning domestic violence and abuse will be kept strictly confidential. No local records will be kept of absences related to domestic violence and abuse and there will be no adverse impact on the employment records because of it.

Any improper disclosure of information will be taken seriously and may be subject to disciplinary action.

Managers, Occupational Health and others with responsibility for employee health and well-being to whom a disclosure is made should address the issue positively and sympathetically and are not required to counsel victims but offer information, ongoing workplace support, and signposting to other organisations.

It is expected that the Trust will work together cooperatively to help staff experiencing domestic violence and abuse, and Line Managers will treat unplanned absences and temporary, poor timekeeping sympathetically where it has been reported. Line Managers may offer employees experiencing domestic violence and abuse a broad range of support and should identify what actions can be taken to increase their personal safety as well as the risk to colleagues. The safety of employees who disclose that they are experiencing domestic violence and abuse should be the priority.

Line managers will respect the right of staff to make their own decision on the course of action at every stage. It must be recognised that the employee may need some time to decide what to do and may try a range of different options during this process.

All cases where employees have raised the issue of violence in relationships should be discussed with the safeguarding team to ensure appropriate advice and response.

5.2.8 Employee Perpetrators of Domestic Violence

Domestic violence and abuse perpetrated by employees will not be condoned under any circumstances nor will it be treated as a purely private matter. The Trust recognises that it has a role in encouraging and supporting employees to address violent and abusive behaviour of all kinds. If an employee approaches the Trust about their own abusive behaviour, the Trust will provide information about the services and support available to them and will encourage the perpetrator to seek help (see Appendix 6 for guidance).

The Trust will treat any allegation, disclosure or conviction of a domestic violence and abuse-related offence on a case-by-case basis with the aim of reducing risk and supporting change. However, employees are subject to the organisation's Managing Allegations Policy and Safeguarding Children and Vulnerable Adult Policies and Procedures, and the Trust also reserves the right to consider the use of these policies should an employee's activities outside of work have an impact on their ability to perform the role for which they are employed, and/or be considered to bring the organisation into disrepute. In some circumstances it may be deemed inappropriate for the individual to continue in their current role: in which eventuality, the possibility of redeployment into an alternative role will be considered.

The Trust views the use of violence or abusive behaviour by an employee, wherever this occurs, as a breach of the organisation's Safer Working Practice (SWP) Guidance for disciplinary purposes. The Trust's SWP guidance is intended to inform all staff, irrespective of grade, of the standards of conduct expected of them. It identifies a set of principles governing behaviour by which staff members are expected to abide. Staff members are always expected to present high standards of personal integrity and conduct that will not reflect adversely on the organisation and its reputation.

The approach identified above can be applicable in cases where an employee has:

- behaved in a way that has harmed or threatened their intimate partner or family member.
- possibly committed a criminal offence against their intimate partner or family member.
- had an allegation of domestic abuse made against them.
- presented concerns about their behaviour within an intimate relationship.

The Trust is committed to ensuring that:

- allegations will be dealt with fairly and in a way that provides support for the person who is the subject of the allegation or disclosure.
- all employees will receive guidance and support.
- confidentiality will be maintained, and information restricted only to those who have a need to know.
- investigations will be thorough and independent.
- all cases will be dealt with quickly, avoiding unnecessary delays.
- efforts are made to resolve the matter within 4-6 weeks (although some cases will take longer because of their nature or complexity).

This procedure is intended to be safety focussed and supportive rather than punitive and the alleged perpetrator will be treated fairly and honestly, helped to understand the concerns expressed and processes involved, kept informed of the progress and outcome of any investigation and the implications for any disciplinary process and advised to contact their union or professional organisation.

There are four potential strands in the consideration of an allegation:

- a police investigation of a possible criminal offence
- disciplinary action by the employer
- providing specialist, safety-focused counselling
- identifying risk

If a colleague is found to be assisting an abuser in perpetrating the abuse (by giving them access to facilities such as telephones, email, or fax machines for example) then they will be seen as having committed a disciplinary offence.

If it becomes evident that an employee has made a malicious allegation that another employee is perpetrating abuse, then this will be treated as a serious disciplinary offence and action will be taken.

5.2.9 Guidance for When the Person Experiencing Domestic Violence and Abuse and the Perpetrator Both Work for the Trust

In cases where both the person experiencing domestic violence and abuse and the perpetrator work in the organisation, the Trust will take appropriate action to safeguard the individuals. In addition to considering disciplinary action against the employee who is

the perpetrator, action may need to be taken to ensure that the person experiencing domestic violence and abuse and the perpetrator do not come into contact in the workplace.

Action may also need to be taken to minimise the potential for the perpetrator to use their position or work resources to find out details about the whereabouts of the person experiencing domestic violence and abuse. This may include a change of duties for one or both employees or withdrawing the perpetrator's access to certain computer programmes or offices. However, it is also recognised that in certain circumstances, those experiencing and perpetrating domestic violence and abuse in a relationship may choose to seek solutions jointly, and in such situations appropriate support should be given.

5.3 Role of Colleagues

The Trust encourages all employees to report if they suspect a colleague is experiencing or perpetrating abuse. Employees should speak to their line manager about their concerns in confidence. In dealing with a disclosure from a colleague, employers should ensure that the person with concerns is made aware of the existence of this policy.

6. Monitoring Compliance and Effectiveness

Monitoring Requirement:	Compliance with this policy, monitored by audit
Monitoring Method:	1) Audit of nursing records for performance of the RE (1 x yr via Ward Assurance visits) 2) Multi-disciplinary documentation audit of handheld records (quarterly; Midwifery BU) Collation of figures on Trust referrals to MARAC
Report Prepared by:	1) SALN 2) Head of Midwifery
Monitoring Repo	Safeguarding Committee
Frequency of Report	Annually

7. References

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Appendix 1 - Indicators of Domestic Violence and Abuse

Most incidents of domestic violence and abuse happen behind closed doors and the assaults or incidents of threatening behaviour / language by the perpetrator are not commonly seen. If you do witness something that causes you concern, do not ignore it.

The following are also signs that someone may be exposed to domestic violence and abuse. None of the following are proof that abuse has definitely occurred, and they should not be taken as such, but they should prompt health professionals to ask further questions, carefully and tactfully.

Qualities in a Relationship

- Jealousy and possessiveness from a partner, including monitoring the person's movements, constantly texting and calling them.
- Partner or family member cutting the person off from their family and friends. This could also include denying them access to medical appointments or controlling visitors.
- Partner or family member has frequent mood swings (ie nice one minute and abusive the next)
- Partner or family member controlling what the person does, who they see, what they wear. They may be very reluctant to allow you to see the patient alone.
- Partner or family member blames the person for the abuse.
- Partner or family member humiliates or insults the person in front of others.
- Partner or family member constantly criticises the person.
- Partner or family member uses anger or intimidation to make the person comply with their wishes.
- Partner or family member tells the person that they are useless and couldn't cope without them.
- Person is having to change their behaviour to avoid making their partner or family member angry.

Signs and Symptoms in Adults

Presentation with:

- Unexplained, inconsistent, or apparently unlikely explanations for injuries.
- A substantial delay of reporting of incident, especially where this is in a hesitant, embarrassed, and evasive manner.
- Multiple injuries in various stages of healing, especially to the head neck, breast, abdomen, and genitals.
- Repeated or chronic injuries (examine previous records)
- Injuries restricted to areas hidden by clothing.
- Rape and sexual assault.
- Higher rates of sexually transmitted diseases including HIV.
- Chronic pain or pain due to diffused trauma without physical evidence.
- Frequent visits with vague complaints or symptoms without evidence of physical abnormality.
- Stress, anxiety disorders or depression, panic attacks, feelings of isolation, inability to cope, suicide attempts or self-harm.
- Frequent use of prescribed tranquillisers or pain medications.

In women who are pregnant:

- Gynaecological problems such as frequent vaginal and urinary tract infections, dyspareunia, and pelvic pain.
- Recurrent admissions for abdominal pain, reduced foetal movements or urinary tract infection.
- In the postnatal period, removal of perineal sutures

Behavioural signs:

- Missed appointments and/or non-compliance with treatment regimes.
- Lack of independent transportation, access to finances and ability to make telephone contact.
- Denial or minimisation of the violence and abuse.
- Reactions such as: numbness, denial, shaking, crying, anger, self-blame for the abusive behaviour, replaying of memories.
- The person may appear frightened, ashamed, evasive, embarrassed or be reluctant to speak or disagree in front of the perpetrator. They may avoid eye contact and look at the perpetrator before answering any questions put to them.

History of:

- Smoking, alcohol misuse, and drug abuse.
- Chest pain, panic attacks and palpitations.
- Unplanned or unwanted pregnancy/terminations of pregnancy.
- A high incidence of miscarriage and termination of pregnancy.
- Stillbirth.
- Pre-term labour/prematurity.
- Intrauterine growth retardation/low birth weight.

Signs and Symptoms in Children

Presenting with:

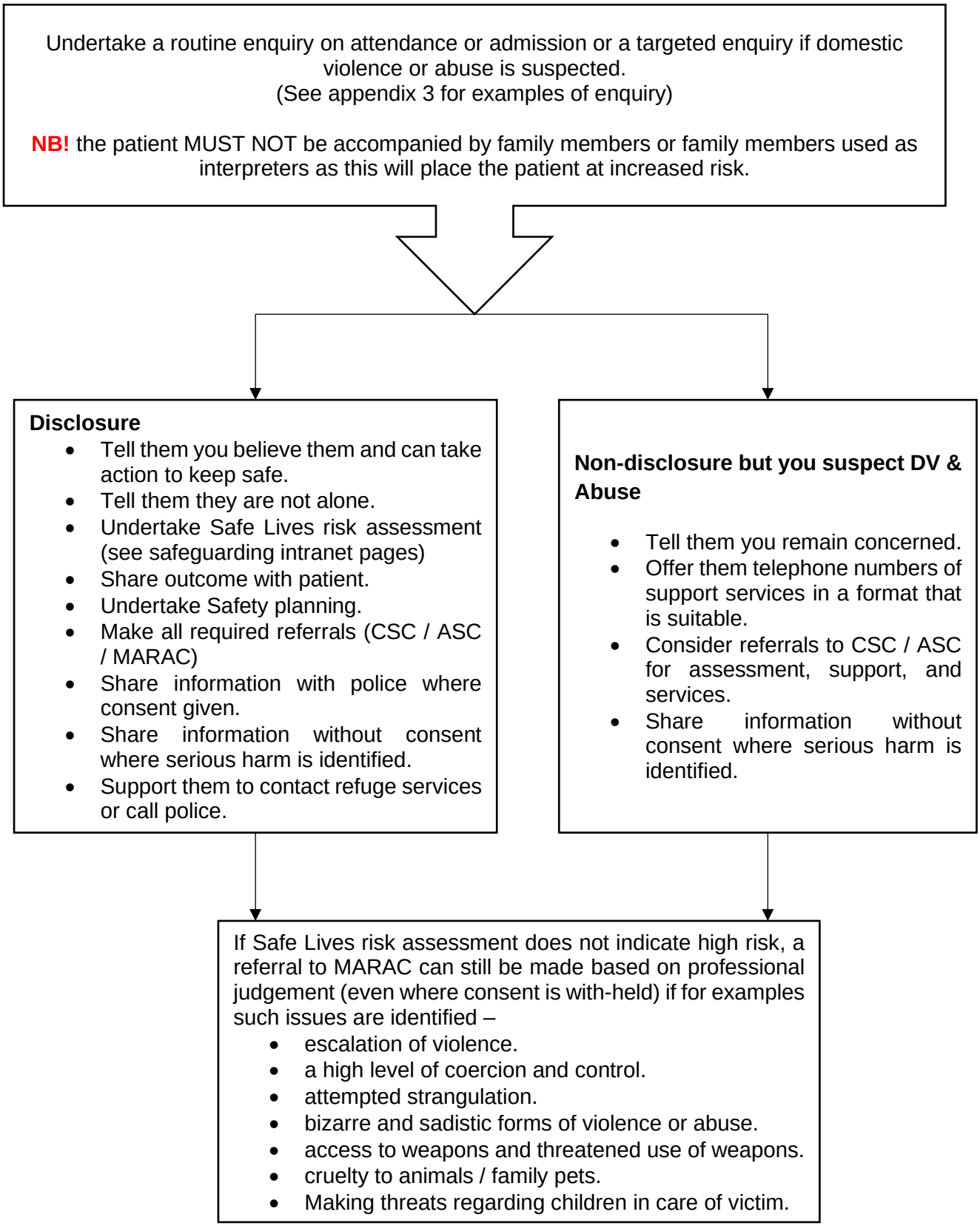
- Anxiety or depression, including self-harm.
- Difficulty sleeping (including nightmares and flashbacks, bed wetting).
- Eating disorders.
- Unexplained physical symptoms such as tummy aches.

Behavioural signs:

- Appearing easily startled
- Temper tantrums
- Aggression, or internalising their anger and withdrawing from people.
- Appearing much younger than they are.
- Problems at school, including deterioration in attainment and truancy. They may be staying at home to try to protect the victim.
- Older children may run away or start to use alcohol or drugs.
- A lowered sense of self-worth.
- Highly gendered expectations of behaviours / achievement / roles.

Please note this list is not exhaustive but is an indicator of some of the signs and symptoms that may cause concern and prompt you to make a targeted enquiry.

Appendix 2 - Domestic Violence / Abuse; Staff response flowchart



Appendix 3 - Enquiries concerning Domestic Violence

It is recognised that staff can sometimes feel uncomfortable discussing the issue of domestic violence and abuse, even though it is a justifiable professional concern and there is no need to do so.

These examples will help you to gain some useful information about the environment and circumstances in which your patient is living and can help you to introduce the topic in a sensitive manner.

Framing Questions

- Unfortunately, violence often plays a role in our families and communities, so I am required to ask all my patients the following question.
- At Royal Derby Hospital, we recognise that violence and abuse is common in our patients' lives, so I must routinely ask about this.

Indirect Enquiries

- How are things at home / in your relationship?
- How do you feel about going home? Do you feel safe?
- What kind of support do you have at home?
- What is your relationship like?
- How does your relationship make you feel about yourself?
- How do you tend to settle arguments in your relationship?
- Does anyone at home use drugs or alcohol excessively?

Direct Enquiries

- I've noted a bruise/cut/burn mark and I'm worried that someone has hurt you. How did it happen?
- Have you/your children/your pets been hit/kicked/punched or hurt by anyone in the past year? If yes – Who by?
- Is physical violence ever used in arguments at home?
- Has anyone ever threatened to hurt you/your children/your pets?
- Has anyone made you feel that if you don't have sex with them, you will be hurt in some way? Has anyone attempted to strangle you during sex or asked you to go along with strangulation?
- Does anyone at home stop you contacting family/friends?
- Does anyone at home stop you from doing things that you like to do or control where you go?
- Does anyone phone you/text you/follow you all the time when you don't want them to?
- Does anyone at home do or say anything that makes you frightened?
- Are you afraid at home? If yes – What of?

These questions are intended as prompts, and it will not always be necessary to ask them all but will depend on individual circumstances. You must, however, ensure that you ask at least one direct question that clearly indicates to the patient that you are asking about domestic violence and abuse.

Appendix 4 - Language Identification Chart For Booking Of Interpreters

Unë flas Shqip	Albanian
አማርኛ፡ እችላለሁ።	Amharic
انا اتكلم اللغة العربية	Arabic
Ես Հայերէն կը խօսիմ	Armenian
Мән азәрбајан дилиндә данышырам	Azeri
আমি বাংলা ভাষায় কথা বলি	Bengali
Govorim bosanski/hrvatski	Bosnian/Croatian
Аз говоря български	Bulgarian
ကျွန်ုပ် မြန်မာလိုတတ်ပါသည်။	Burmese
我說粵語	Cantonese
Mluvím česky	Czech
I speak English	English
Ma räägin Eesti keelt	Estonian
من فارسی حرف میزنم	Farsi
Je parle français	French
მე ვლაპარაკობ ქართულად	Georgian
Ich spreche Deutsch	German
હું ગુજરાતી બોલું છું	Gujerati
NA YIA HAUSA	Hausa
אני דובר עברית	Hebrew
मैं हिन्दी बोलता हूँ	Hindi
Beszélek Magyarul	Hungarian
Anam asu igbo	Ibo
Saya bicara bahasa	Indonesian
Мен казахша билемин	Kazakh
Nvuga ikinyarwanda	Kinyarwanda
나는 한국말을 합니다	Korean
من بەکوردی قسە ئەکەم	Kurdish
Es runāju latviski	Latvian
Na lobaka Lingala	Lingala
Aš kalbu lietuviškai	Lithuanian
Јас зборувам македонски	Macedonian
Saya bicara bahasa Malay	Malay
我说汉语	Mandarin
मी मराठी बोलतो	Marathi
Би Монгол хэлээр ярьдаг	Mongolian
म नेपाली बोल्छु	Nepali
Mówię po polsku	Polish
Falo Portugues	Portuguese
ਮੈਂ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹਾਂ	Punjabi
زه پښتو خبرې کولای شم	Pushto
Vorbesc limba română	Romanian
Я говорю по-русски	Russian
Ја говорим српски	Serbian
Ndino taura Shona	Shona
මම සිංහල භාෂාව කථාකරමි	Sinhalese
Rozprávam po slovensky	Slovak
Waxan ku hadlaa af Soomaali	Somali
Hablo español	Spanish
Ninasema Kiswahili	Swahili
Marunong ako magsalita ng Tagalog	Tagalog
நான் பேசும் மொழி தமிழ்	Tamil
ผมพูดไทย	Thai
నేను తెలుగు మాట్లాడతాను	Telugu
ትግርኛ እዛረብ እየ።	Tigrignia
Türkçe konuşuyorum	Turkish
Meka Twi	Twi
Я розмовляю по-українськи	Ukranian
میں اُردو بول سکتا ہوں	Urdu
Мен ўзбекча гапираман	Uzbeck
Chúng tôi nói tiếng Việt	Vietnamese
mo lè so yoruba	Yoruba

Appendix 5 Resources / Information

SARC is a specialist service for anyone of any age, male or female who have been raped or sexually assaulted. They are open 24 hours per day, seven days per week. They aim to provide medical care and forensic examination following assault or rape, counselling, and sexual health services. For those not wanting to report to the police, self-referrals are accepted. To preserve any evidence that may be present it is vital that help from the SARC is accessed as immediately as possible after an assault. In addition, the SARC can advise on and assist with other medical needs.

1 Nottinghamshire SARC	The Topaz Centre – Nottinghamshire SARC - NG5 6FZ Telephone 08000859993 - 24/7 Oxclose Lane Arnold, Nottingham NG56FZ
2 Derbyshire SARC	Millfield House, 36 Hall Street Alfreton Derbyshire DE55 7BU 01332 413 260 (24/7)
3 Staffordshire SARC	Grange Park Cobridge Community Health Centre Church Terrace Cobridge Stoke-on-Trent ST6 2JN Phone: 0800 970 0372
4 Leicestershire SARC	Juniper Lodge Tel: 0116 273 3330

Independent Domestic Violence Support

1 Staffordshire

Specially trained New Era staff can help you, whether you've made a report to the police or not.

New Era provides a range of advocacy services, including help with

- obtaining a non-molestation and other orders;
- housing issues and access to refuge and other emergency accommodation;
- advocacy with the police and other statutory services;
- child contact matters and court visits;
- accessing counselling and a range of other services.

New Era has dedicated specialist advisors working exclusively with LGBT+ (Lesbian Gay Bi-sexual Transgender), BAMER (Black Asian Minority Ethnic and Refugee) and male victims.

Telephone 03003033778

2 Derby & Derbyshire

In Derbyshire, our team can carry out risk assessments and develop both short and long-term safety plans to support you and your children.We can also support you through the court process and where we can't help, we can signpost you to other specialist services for extra support.We can explain the system and help you access housing, health, education, financial and family services to help them build a life free from abuse.

If you're in Derby County you can find support by calling Derbyshire domestic abuse helpline: 0800 019 8668

If you're in Derby City you can find support by calling Refuge: 0800 085 3481

3 Nottinghamshire

NOTTINGHAMSHIRE WOMEN'S AID

The Farr Centre, Chapel Walk, Westgate

Nottinghamshire

S80 1LR

Phone: 01909 491330

Fax: 01909 533617

24hr Freephone Helpline:

0808 800 0340

4 Leicestershire

Domestic and sexual violence advice line tel:08088020028

Domestic Abuse - Perpetrator programmes

1 Derbyshire

Domestic Abuse Helpline

Telephone 08000 198 668

07534 617 252

Email: derbyshiredahelpline@theelmfoundation.org.uk

Live Chat: www.theelmfoundation.org.uk

2 Staffordshire

Perpetrator support is offered by the Staffordshire & West Midlands Community Rehabilitation Company; the Reducing Re-Offending Partnership (RRP) working here across Staffordshire and Stoke-on-Trent.The support is based on the voluntary participation of the perpetrator and RRP will work with individuals to understand the most appropriate individual or group work programme using a range of evidence based interventions. Accredited Programme's such as Spectrum and Building Better Relationships are available and operate from short term (10 weeks) to more intensive timeframes (up to 30 weeks). A specialist Out of Court Disposal programme is under development and will be available soon.

Getting help to change your behaviour

Your first step to getting help is to contact New Era. Call 01785 601 690 and speak to someone now.

For more information on the help available from New Era to help perpetrators change their behaviour, visit: http://www.rrpartnership.com/new-era

Agency referrals: new-era@victimsupport.cjsm.net

3 Nottinghamshire

Equation - The Jenkins Centre

01156950734

Monday to Friday, 9am – 5pm excluding bank holidays.

Appendix 6 - Guidance on Information Sharing

The following questions may help in deciding whether information should be shared without consent:

1. Do you have a legal power to share information?
To share information lawfully, you must have the legal power to do so. The Crime and Disorder Act 1998 (s115) provides legal power to share information for the purposes of the act, which is crime prevention. This will apply in the majority of cases of domestic violence.

2. Are you in compliance with Article 8 of the European Convention on Human Rights 1998?
Sharing of information that may interfere with rights under Article 8 (Respect for Private and Family Life, Home and Correspondence) may be justified where it is in the interests of national security, public safety or economic well-being of the country, for the prevention of disorder of crime, the protection of health or morals or the protection of the rights and freedoms of others. Clearly, there will be many examples of cases where sharing information in domestic violence cases will be justified in respect of the interests listed - particularly those relating to public safety and the protection of others eg children, young people and vulnerable adults.

3. Are you in compliance with common law obligations of confidence?
Common law requires that information may not lawfully be disclosed when given in certain circumstances of confidentiality (e.g., nurse/patient). However, the duty of confidentiality is not absolute and can be justified where there is an overriding public interest, which can include domestic violence and child protection (as above).

4. Are you compliant with the Data Protection Act 1998?
The Data Protection Act 1998 allows for personal and sensitive information to be shared without consent in order to protect a client and/or any children under 'public interests' exemptions. Professionals will need to continually assess whether the situation warrants sharing information, and if that should be done on a basis of consent.

You should continually assess whether the situation warrants sharing information, and if that should be on a basis of consent. If it is felt that information must be shared to protect individuals from actual/potential harm then you should do so; clearly recording whether consent was or was not obtained, the justification for sharing the information, and what was shared, by whom and with whom, and for what purpose.

Always discuss these cases with the Trust Safeguarding Team.

Appendix 7 - Working with employee perpetrators of Domestic Violence and Abuse.

Some perpetrators do not recognise that their behaviour constitutes domestic abuse, however, all perpetrators are responsible for their behaviour and should be held accountable for it. A desire to exert power and control is commonly recognised as the key motive for perpetrators. Younger males are more likely to be perpetrators and there are multiple complex risk factors that can influence whether someone may perpetrate domestic abuse. Perpetrators may manipulate victims and/or those around them to hide or normalise abusive behaviours. Domestic abuse perpetrators can be particularly adept at manipulating professionals, agencies and systems and may use a range of tactics to perpetuate contact with, and exert control over, the victim. Perpetrators may seek to minimise allegations, normalise the behaviour and discredit reports of abuse.

Perpetrator behaviours can potentially include:

- Disguised compliance, missing or cancelling appointments, non-attendance, playing different professionals off against one another;
- Making false or vexatious allegations against victims and convincing professionals that their controlling tactics are for the victim's own safety and/or for the safety of their children;
- Using the courts to continue abuse, for example not turning up to court dates, sending unnecessary and repeated legal letters and making threats around contact;
- Making counter-allegations against the victim
- Exploiting interpretations of religion or faith to maintain control of victims and perpetuate harm;
- Using children as a form of control – e.g. access visits, seeking to manipulate children's feelings towards ex-partner (the victim);
- Attempting to frustrate or interfere with a police investigation, including attempting to undermine the victim's statements by claiming they are mentally ill;
- Use of family members, new partners, or others to indirectly communicate with or threaten the victim, especially in cases where the perpetrator is under investigation, subject to a protection order or detained;
- Use of false profiles on social media or other technology platforms;
- Telling the victim that they will not be believed because they have mental health issues, learning difficulties or disabilities, or issues with substance abuse;
- Threatening to 'out' the victim as a form of coercive control, telling the victim that they will not be believed because they identify as lesbian, gay, bisexual and/or trans, or manipulating the victim's knowledge of what support is available for LGBT people and using myths and stereotypes around LGBT domestic abuse to make professionals believe that abuse between same-sex couples does not exist;
- Threatening to remove care or not undertake caring responsibilities where the victim is reliant on this, threatening the victim around the withdrawal of medicines;
- Exploiting the communication support needs of the victim or manipulating the victim's knowledge of what support is available and making professionals believe that the victim does not have capacity to report accurately or that reports are not credible due to communication difficulty;
- Using threats to manipulate the victim, for example, by telling the victim they will not be believed by the police or other agencies, that they will inform social services, that their children will be taken away;

- Seeking to control the victim's finances, ability to access funds or obtain an income; and manipulating the victim's immigration status as a form of coercive control, including withholding ID, passports and visas from the victim, lying about their status, purposely letting a victim's visa lapse or failing to act on sponsorship duties for immigration purposes It is recognised that health care professionals may be one of the few groups to whom perpetrators of domestic violence and abuse may disclose and it is important to be open to the possibility that your patient may be violent or abusive to a family member. It is important to be clear about confidentiality, and the limitations of this, when making enquiries. Sensitive and direct exploration may enable a disclosure.

Simply asking "How are things at home?" may be enough to prompt disclosure, but other suggested follow-up questions include:

- Do you argue a lot with your partner?
- Have you ever pushed/slapped/hit your partner or used other force?
- Do you smash things/shout a lot/put your partner down?
- What are you like when you argue?
- How would your partner describe how you are in an argument?
- What are you most ashamed about doing to your partner?

It is important that you acknowledge that their disclosure is a first step towards choosing to change their behaviour. Affirm any accountability shown by them and be respectful and empathetic but avoid colluding with them.

Do not:

- Assume that accessing help for alcohol or drug services will stop their abusive behaviour. They may need help for their substance misuse alongside help for their abusive behaviour.
- Assume that anger management or couples counselling are appropriate. These can be potentially dangerous interventions where there is domestic violence and abuse.
- Assume that medication will "fix" domestic violence and abuse. **It is not a medical issue.**

See Appendix 5 for details of services to address perpetrator behaviour

Appendix 8 - Options for supporting employees disclosing domestic violence and abuse

A broad range of support can be offered to staff which may include (but is not limited to):

- Special paid leave for relevant appointments including with support agencies, solicitors, to rearrange housing or childcare, and for court appointments
- Temporary or permanent changes to working times and patterns (to ensure that the individual does not work alone, or in isolated areas, for example)
- Changes to specific duties (to avoid potential contact with an abuser in a customer-facing role, for example)
- Referral to Occupational Health
- Referral to the Employee Assistance Programme
- Redeployment or relocation to allow the individual to work, or travel to and from work, safely (for example). (Care should be taken to emphasise that this is not a punitive measure.)
- Measures to ensure a safe working environment, such as changing a telephone number to avoid harassing phone calls
- Using other existing policies, including flexible working
- Access to counselling and/or support services in paid time
- Access to courses developed to support female survivors of domestic abuse, for example The Freedom Programme www.freedomprogramme.co.uk) or assertiveness training
- In some circumstances, an advance of pay will be considered
- Access to hospital accommodation