University Hospitals of Derby and Burton NHS Foundation Trust

POLICY & PROCEDURES REGARDING DOMESTIC VIOLENCE AND ABUSE

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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
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Training and Dissemination: Training is by elearning / face to face sessions advertised on the intranet.				
To be read in conjunction with: Managing Allegations policy (where staff are involved as either victim of perpetrator)Safeguarding Children Policy and Safeguarding Adult Policies				
In consultation with and Date: Trust Safeguarding Operational Reference Group (TSORG) and Trust Safeguarding Committee (TSC)				
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Contact for Review	Trust Safeguarding Lead
Executive Lead Signature	Executive Chief Nurse and Director of Patient Experience
Approving Executive Signature	Executive Chief Nurse and Director of Patient Experience

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1. Introduction

Domestic abuse is defined as "Any incident of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- **psychological**
- **physical**
- **sexual**
- **financial**
- **emotional**

Controlling behavior is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploring their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behavior.

Coercive behavior is an act or pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

The definition includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage.

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.

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 of individual members of staff; retain valued employees; improve morale and performance; and enhance the reputation of the Trust as an employer of choice. 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.

This policy applies to all staff across all sites as well as agency and contract staff.

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 strategic direction that reflects national guidance, including the Trust's obligations under the Care Act (2014), 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 and Explanation of Terms

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.

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.

Honour-Based Violence: Where an individual is being punished by their family and/or community for behaving in a manner that is believed to have brought shame or dishonour. It includes acts of harassment, assault, imprisonment, unexplained death (including suicide), forced pregnancy / abortion and, in some cases, 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)

Perpetrator: A person who abuses another person.

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.

EDIS: This stands for "Emergency Department Information System" and is the system used to record patient attendance in the Emergency Department at the Royal Derby Hospital site.

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 or not the local authority is meeting those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result 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).

LSCB: This stands for "Local Children's Safeguarding Board".

SAB: Safeguarding Adult Boards

CSC: Children's social care

ASC: Adult social care

4. Key Responsibilities/Duties

4.1 Safeguarding Adult Boards and Safeguarding Children's Boards(Staffordshire, Derbyshire and Derby City Local Authorities)

Safeguarding Adult / Children's Boards (SAB/SCB) 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

4.2 Clinical Commissioning Groups (South Derbyshire Clinical Commissioning Group (SDCCG) and NHS East Staffordshire (ESCCG))

The South Derbyshire Clinical Commissioning Group (SDCCG) and NHS East Staffordshire (ESCCG) monitor Trust performance in safeguarding in regular meetings with the Trust.

4.3 Executive Chief Nurse

The Executive Lead 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/SCB.

4.4 Trust Designated Adult Safeguarding Manager (DASM)

The Trust DASM is an identified HR representative of sufficient seniority to ensure that a strategic overview is taken of issues relating to staff performance and management of allegations of domestic abuse perpetrated by staff or staff who may be victims of domestic abuse.

4.5 Trust Safeguarding Lead

The Trust Safeguarding Lead is responsible for alerting the Trust Safeguarding Committee and Lead Executive Officer to any concerns or shortfalls in safeguarding practice within the Trust, advising with regard to the impact of relevant policy, enquiries or legislation, development or review of Safeguarding training and Trust Policy and Procedures for Safeguarding. The Trust Safeguarding Lead is also responsible for advice and support offered by the safeguarding team to staff and teams within the Trust.

4.6 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.

4.7 Trust Safeguarding Committee (TSC)

The TSC meets quarterly and oversees that national developments regarding safeguarding are incorporated into Trust policies and processes. They also receive reports and monitor the implementation of adult safeguarding processes throughout the Trust, agree assurance / escalation

reports to the Trust Quality Review Group and Quality Committee

4.8 Trust Safeguarding Operational Reference Group

Meets quarterly and acts as a reference and consultation group for policies and procedures and escalation of issues from front-line practice which can impact on delivery of safeguarding best practice.

4.9 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.
- Must enter any safeguarding incident **where it is alleged that it has been caused by hospital employees / processes** into the Datix Incident reporting system.
- 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

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 victims flowchart is at appendix 2

5.1 Making Enquiries

All health professionals have a duty to make a routine enquiry to all patients and targeted enquiries where there is a reason to suspect that it is an issue. Examples of routine and targeted enquiries can be seen at appendix 3.

If family members are present, domestic violence and abuse issues should not be discussed as this could increase the risk of reprisals if the perpetrator thinks that the patient is making a disclosure. 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. **Family or friends should never be used to interpret questions of this kind.**

5.2 Routine Enquiry Regarding Domestic Violence and Abuse, and Recording of Concerns / Disclosures

5.2.1 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 EDIS record noting a positive (RE+ve) or negative (RE-ve) response.

In Burton sites responses should be documented on the v6 record

5.2.2 On admission to hospital, 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.

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

5.2.3 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

5.2.4 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 at least three times during pregnancy: at least twice ante-natally and at least once in the post-natal period. This must be clearly documented on the Maternity Hand Held 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 Safe Lives risk assessment must be undertaken with any woman reporting a positive response during pregnancy

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 should additionally be contacted in order that an alert can immediately be placed on their emergency department record

5.3 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 Safe Lives (previously CAADA DASH) 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 of 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 first 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 patients consent.

Ward strategies may be required in the event that 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.

Consideration should then be given to preserving evidence of any recent violence by retaining clothing and/or bed linen, photographing injuries (requested via Medical imaging on the Clinical Photographic Consent Form), completing a Body Map (safeguarding intranet) or offering referral to the area SARC in cases of rape or sexual assault. 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 in order 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.

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

The outcome of the 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 on the basis of professional judgement and such indicators include; escalation of violence / a high level of coercion and control / attempted strangulation / bizarre and sadistic forms of violence or abuse / access to weapons and threatened use of weapons.
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. Leaflets are available in a range of languages (www.gov.uk/government/publications/three-steps-to-escaping- domestic-

violence)

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.

Documentation 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.

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.

5.4 Safety Planning

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

- Advise to keep their mobile phone fully charged and with them at all times
- 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).

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

5.5 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 in order 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 or not 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. 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 4.

5.6 Employees 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.

5.7 Employees Experiencing Domestic Violence

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 or 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 Safe Lives risk assessment and safety planning should take place as offered to patients above.

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 in order 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 as a result of it.

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

Managers/ Supervisors or Union Representatives 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 and Union Representatives 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.

5.8 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 2 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 expected at all times 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.

5.9 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 (see . 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.

5.10 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:	Audit of nursing records for performance of the RE (1 x yr) Multi-disciplinary documentation audit of handheld records (quarterly) Ward Assurance visits Collation of figures on Trust referrals to MARAC
Report Prepared by:	SALN
Monitoring Report presented to:	Safeguarding Committee
Frequency of Report	Annually

7 References

British Medical Association (1998) Domestic abuse: A Health Care Issue? *London, British Medical Association*

Bewley et al. (Eds) (1997) Violence Against Women *London, Royal College of Obstetricians and Gynaecologists*

Co-ordinated Action Against Domestic Abuse (CAADA) (2010) Saving lives, saving money: MARACs and high risk domestic abuse. *Bristol, CAADA*

Centre for Midwifery Education (CMACE) (2011) Saving Mother's Lives. Reviewing Maternal Deaths to make Motherhood Safer 2006-2008 *BJOG: AN International Journal of Obstetrics and Gynaecology Volume 118, Supplement 1, March 2011*

Department of Health (2005) Responding to domestic abuse: a handbook for health professionals*. London, Department of Health*

Department of Health (2012) "Striking the Balance" Practical Guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (Multi Agency Risk Assessment Conferences. *London, Department of Health*

Department of Health (2014) Care and Support Statutory Guidance. Issued under the Care Act 2014. *London, Department of Health*

Equality and Human Rights Commission (2013) Managing and Supporting Employees Experiencing Domestic Abuse. A guide for employers *London, CIPD*

Home Office (2012) Ending violence against women and girls in the UK. *London, HMSO*

Humphreys C (2006) Domestic violence and child protection: exploring the role of perpetrator risk assessments. *Child and Family Social Work* 12 (4), 360-369

Johnson et al. (2003) The prevalence of domestic abuse in pregnant women *BJOG: An International Journal of Obstetrics and Gynaecology* 110(3), 272- 275

Local Government Association (2013) Adult safeguarding and domestic abuse: A guide to support practitioners and managers *London, Local Government Association*

National Institute for Clinical Excellence (2008) Antenatal Care *London, NICE*

National Institute for Health and Care Excellence (2013) Domestic violence

and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse. Public health Draft Guidance. *London, NICE*

Ramsey et al. (2002) Should health professionals screen women for domestic abuse? *British Medical Journal* 325: 314

Respect / NHS Barking and Dagenham (2008) Domestic Violence Working With Perpetrators – A Guide for Health Care Professionals*. London, NHS Barking and Dagenham*

Respect (2011) Domestic Violence Perpetrators. Working with the cause of the problem. *London, Respect*

Royal College of Midwives (1997) Domestic Abuse in Pregnancy, Position Paper Number 19 *London, Royal College of Midwives*

Women's Aid Federation of England (2001) Health and Domestic abuse : A Life and Death Issue *Bristol, Women's Aid*

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 really 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 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

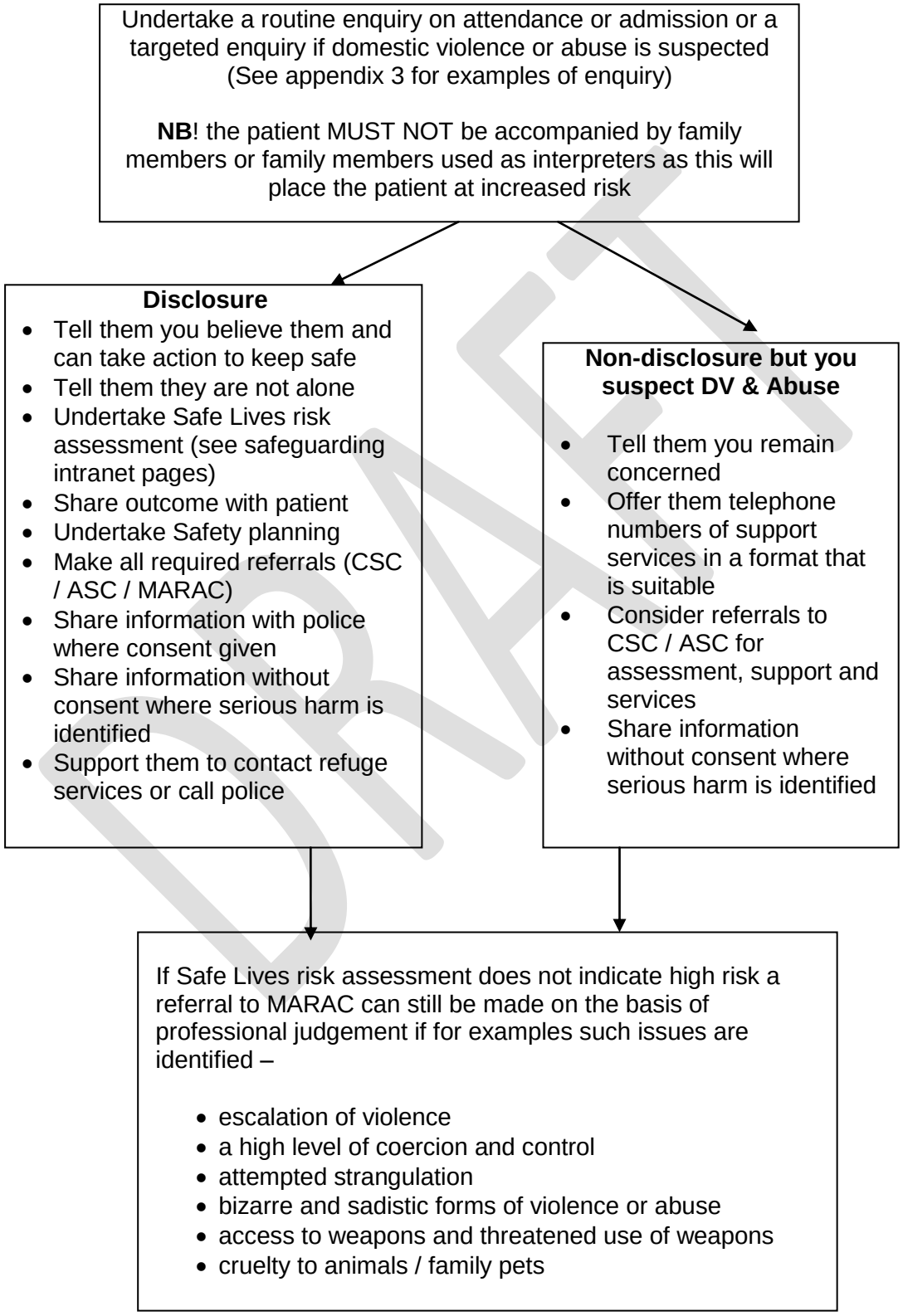
Behavioural signs:

- 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 of 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?
- 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.

LANGUAGE IDENTIFICATION CHART

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 sọ yoruba	Yoruba

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.

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 (eg 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.

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 in order 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.

Appendix 6

WORKING WITH PERPETRATORS OF DOMESTIC VIOLENCE AND ABUSE

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.

Give the perpetrator the Respect Phoneline – 0808 802 4040.

This is a confidential advice line for people worried about their abusive behaviour and can assist them to access programmes to help address their behaviours.

The Respect Phoneline is also able to offer information and advice to health care professionals who have contact with people who are being abusive on how to safely manage this.

Appendix 7

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 Consideration may be given to:

- 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