Document Control

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1. Purpose

1.1. The purpose of this document is to detail the process for Northern Devon Healthcare Trust's system for recognising the signs of, and dealing with patients who are experiencing domestic violence and abuse. It provides a robust framework to ensure a consistent approach across the whole organisation.

1.2. Violence against women or men by partners is referred to as either domestic abuse or domestic violence.

Throughout this guidance the term 'domestic abuse' is used instead of 'domestic violence', as the latter is often misconstrued as being physical abuse only.

1.3. The policy applies to all Trust staff.

1.4. Implementation of this policy will ensure that:

- Improve safety and improve health by recognising that domestic abuse is a serious crime which may have an adverse impact on individuals, families and communities.
- Increase knowledge and understanding about the nature of domestic abuse and its impact on those who experience domestic abuse and their dependents
- Comply with the legal framework and current national guidance
- Support effective inter-agency communication
- Provide guidance and support to all staff
- Raise awareness on the incidence of domestic abuse
- Increase the number of NHS staff accessing domestic violence and abuse training courses

2. Definitions

Domestic Abuse

2.1. The cross government definition of domestic abuse is:

2.2. "Any incident or pattern of incidents 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

www.gov.uk/domestic-violence-and-abuse (2016)

Controlling Behaviour

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

Coercive Behaviour

2.4. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten the victim.

2.5. This definition also includes so-called “honour” based violence perpetuated against a person by family or community members

Domestic Abuse is:

- Systematic patterned behaviour designed, consciously or subconsciously, to control and dominate a partner/former partner or a family member

Domestic Abuse is not:

- Solely consisting of acts of physical abuse – it has been recognised that abuse can take the form of sexual, emotional, psychological and financial abuse.
- A minor tiff
- An occasional heated argument
- Loss of temper or self-control
- Caused by alcohol and/or drugs
- A private quarrel

Victim/Survivor of Domestic Abuse

2.6. The term “victim” is often perceived as negative. Some policies refer to those experiencing domestic abuse as “survivors” as they are often surviving the abuse on a daily basis. This policy will use the term “a person subjected to domestic abuse”. This will refer to anyone who has been injured or has been emotionally, financially or sexually abused by a person with whom she/he has or has had an intimate relationship or by a family member.

Child

2.7. A child is anyone who has not yet reached his/her 18th birthday (Children’s Act 1989).

Vulnerable Adult

2.8. A vulnerable adult is a person “who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.

Incidents: Incidents of Domestic Abuse

2.9. On average 112 women a year are killed by a male partner or former partner, and 22 men are killed by their partner. In the LGBT (lesbian gay bisexual and transgender) community the incidence of violence and homicide is the same roughly of that of the heterosexual community. All domestic abuse laws, policies and procedures should be gender neutral and reflect the fact that domestic violence can occur within any intimate relationship. There are sometimes assumptions made about the LBGT community which means that victims can be isolated and feel unable to seek help.

2.10. In any one year, there are nationally 13 million separate incidents of physical violence or threats of violence against women from partners or former partners. Women are much more likely than men to be the victim of multiple incidents of abuse, and of sexual violence: 32% of women who had ever experienced domestic violence did so four or five (or more) times. Approximately 11% of men who have experienced domestic abuse and 89% of women had experienced 4 or more incidents of domestic violence. One third of men killed by their intimate partner in a domestic abuse setting were killed by another man.

2.11. Older people have similar rates of domestic abuse – this might be 'old abuse' from a long standing relationship which has always been abusive or from new relationships formed which result in abusive behaviour. Incidence of domestic abuse in the elderly can increase from age 80 to 89 and levels of violence can be very severe. Elder abuse can encompass many things and sometimes domestic abuse can get lost in the situation. It is important not to make assumptions and keep an open mind about worrying situations in the elderly population. 250,000 people over the age of 66 are at risk of abuse of some kind which could encompass neglect, emotional abuse, physical abuse sexual or financial abuse. 54% of UK rapes are committed by a woman's current or former partner.

3. Responsibilities

Responsibilities of Managers

All managers should:

- Be aware that staff may require further support when they are working with families who are involved in/have experienced domestic abuse.
- Be aware and understand the indicators which may suggest that a patient is experiencing domestic abuse.
- Be aware that staff's own prejudices/feelings about domestic violence and abuse may influence their own decision about how to proceed/respond and ensure appropriate supervision is in place to support staff.
- Ensure that staff have adequate and appropriate training and identify this as part of their Professional Development Plan. This will generally follow the guidance issued by the NHS.
- Identify a domestic abuse representative for each department/area.
- Work in a collaborative manner with the Health IDVAs and the local domestic abuse organisation.
- Ensure staff have the systems in place to maintain confidentiality of records (see Healthcare Records Policy).

- Be aware that domestic violence and abuse is considered in child protection and vulnerable adult cases. It is now recognised that witnessing/overhearing domestic abuse and living in a household where domestic abuse is present, is harmful for children and young people (see Section 0).
- Acknowledge that asking for help, whether it be a staff member or a patient, may leave a person feeling vulnerable and powerless and act accordingly.
- Ensure local statistical data is collected.
- Recognise that due to the prevalence of domestic abuse, it is likely that some members of staff will be experiencing (or will have experienced) domestic abuse which may impact on their work (and/or their response to patients who are experiencing domestic abuse) and may mean that they need to access support services themselves.

Responsibility of Staff Members

All staff should:

- Be aware of the extent and impact of domestic abuse and understand the indicators that may suggest that somebody may be experiencing domestic abuse (See appendix C)
- Be aware that there is a significant overlap between domestic abuse and both child protection cases and vulnerable adult cases.
- Ensure that they attend training that prepares them to recognise domestic abuse and enables them to respond appropriately.
- Recognise that they have a responsibility to acknowledge domestic abuse and respect the need for confidentiality and understand when it is necessary to disclose information. **Never discuss domestic abuse with a patient if someone else is present.**
- Take action to respond appropriately to the individuals' needs and to respect their wishes. Undertake a personal safety assessment and never place themselves at risk of personal injury or substantial intimidation (see Lone Working Policy). Where a potential risk of violence is identified for staff an urgent risk assessment should be completed.
- Be aware of the support services that are available locally and what to do if a patient discloses they are experiencing domestic abuse (or they suspect that a patient is).
  (See appendix D)

Supporting Staff

3.1. Involvement in the protection of those experiencing domestic abuse may be stressful to staff who need to demonstrate a non-judgemental attitude to both victims and carers and establish support and protection. It is important that the impact on staff is recognised and that they are offered appropriate support.

- The Trust will support staff as part of its commitment in the implementation of this policy.
- Where there is likely to be a risk to the personal safety of staff, managers must ensure that appropriate arrangements are made and recorded in line with a "zero" tolerance guiding principle as outlined in the management of violence and aggression.

4. Supporting those experiencing Domestic Abuse

Introduction

4.1. This policy complements and should be used in conjunction, with the more detailed guidance contained in DSCB Safeguarding Children and Young People Affected by Domestic Abuse, DSCB Multi-Agency Child Protection Procedures 2005 and Devon LSVAB Protection of Adults Procedures.

Advice and Support

The aim of staff is to support a person subjected to domestic abuse through the process of seeking advice by the use of signposting to appropriate agencies (See appendices A and E)

4.2. Advice and support for staff dealing with cases of domestic abuse is through the Health IDVAs (Independent Domestic Violence Advisors), Named Nurse or Midwife for Safeguarding Children, vulnerable adult lead or line managers.

5. Recognising Domestic Violence and Abuse

5.1. There are a number of recognised physical, emotional and behavioural signs/symptoms that can raise concern that someone may be experiencing domestic abuse (see Appendix C: Recognition of domestic abuse and barriers to leaving an abusive relationship and seeking help and support). None of the signs automatically indicates domestic abuse but they should raise suspicion and prompt you to make every attempt to see the person alone and in private to ask them if they are experiencing domestic abuse. Even if they choose not to disclose at this time, they will know you are aware of the issues and they may choose to approach you or another health professional at a later time.

6. Procedure for Enquiring about Domestic Abuse and Actions to Take

Who to Screen?

- All pregnant women should be asked about domestic abuse.
- All patients attending an urgent care setting e.g. ED or MIU should be asked “do you feel safe at home?”
- All patients that exhibit indicators of abuse (see Appendix C: Recognition of domestic abuse and barriers to leaving an abusive relationship and seeking help and support) or who are vulnerable adults should also be asked.
- Where the question has not been asked, staff should record the reasons for this omission in the hospital records (**for pregnant women – do not record this in the hand held notes)**.

Who should Screen?

6.1. Where there are concerns about domestic abuse, staff should enquire, and seek advice from a more senior colleague or Health IDVAs where necessary. Both questions and answer should be recorded in the patient's notes. Where the question has not been asked, staff should record the reasons for this omission, and any follow up that may be necessary in the hospital notes.

Creating an environment which assures privacy and Confidentiality

6.2. Those experiencing abuse may find it difficult to raise the subject of domestic abuse themselves or may not recognise that they are experiencing domestic abuse. Health professionals should therefore be prepared to take a pro-active approach. It is important that those subjected to domestic abuse are given regular opportunities to disclose their abuse and lack of disclosure on previous occasions should not preclude raising the issue again, since research shows that repeated questioning increases the likelihood that an individual will tell the practitioner about the abuse.

6.3. All pregnant women should be given a leaflet at their booking appointment which gives them information about domestic abuse.

6.3.1. Individuals should always been seen on their own when being asked about domestic abuse – friends, family members, partners (including those of the same sex) and children of comprehending age should not be present.

6.3.2. **Do not** ask the domestic abuse screening question if the patient is accompanied by another adult who stays or if the patient is accompanied by children unless the child is an infant.

6.3.3. If the patient discloses abuse in front of a friend or family member accompanying them, the practitioner should refer to this policy for assessment and referral of the patient.

6.3.4. If unable to speak to the patient alone in triage or booking, the practitioner should make additional attempts to assess privately. This may be to interview the patient in another private area.

6.3.5. Ensure privacy – make sure you cannot be overheard.

6.3.6. Use professional, preferably same gender, interpreters for individuals who require translation services. Never use friends of the family as they may report back to the abuser what has been disclosed. Be mindful of the fact that interpreters may be part of the adult's local community. This is particularly relevant if there are concerns that a patient may be experiencing so called "honour" based violence. Using an interpreter from the patient's community may put them at significant risk.

Children

6.4. If children are living in the household a MASH enquiry should be made or if the family are already known to social care, their social worker needs to be informed of the incident that has led them to access health services. Domestic abuse is acknowledged as a primary indicator of child protection needs.

- If you have any concerns about the welfare of a child or the safety of a child it is your responsibility to discuss your concerns with your line manager/named nurse/named doctor/named midwife for safeguarding children, ensuring that this does not delay safeguarding the child and/or make a MASH enquiry.
- Ideally an enquiry to MASH should be discussed with the patient and consent sought. Evidence shows that working openly and honestly wherever possible promotes more effective working partnerships with parents. However, this may not always be possible and the health professionals' duty to act in the best interests of the child means that parental agreement is not required where this is refused or where seeking consent could result in further harm to the child. MASH can be contacted on **0345 155 1071** or **0845 600 0388** (Out of Hours).

Vulnerable Adults

- A vulnerable adult is a person "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".
- Domestic abuse can occur regardless of age; however age may affect help seeking and access to services and individuals may face stereotyping because of old age or lack of mental capacity. However if the victim is considered a vulnerable adult who has, or is, likely to experience significant harm due to abuse or neglect a safeguarding "alert" must be made to Care Direct – Devon County Council Adult and Community Services (Social Services). They are contacted via Care Direct on **0845 155 1007.**
- In addition an incident report must be made on the DATIX system. The incident report on DATIX should make it clear that it is a safeguarding adult issue and what actions have been taken. This will then be passed to the alert line manager and the safeguarding adults lead. Subsequent actions will depend on the description of the alert, the part played by NDHT and the level of harm sustained. See the Incident Reporting and Management Policy. The DATIX incident should contain details of the safeguarding concerns as well as actions that have been taken, confirmation that a safeguarding alert has been made.
  (See appendix D)

  Further information about safeguarding adults can be found in the trust Safeguarding Adults Policy.

- Remember it is your responsibility to report or discuss your concerns with your line manager and to record fully all discussions concerning the adult at risk. It is also preferable to get the adult's consent, if possible, prior to involving Social Services.
- If the patient is unable to make decisions for themselves and they are being subjected to domestic abuse by their next of kin, it is advisable to contact an Independent Mental Capacity Advisor, who will then act on the victim's behalf and in their best interest.

How to ask the Screening Question

6.4.1. The screening question should begin by framing the question so that the patient understands that this is a routine question asked of every patient and that their confidentiality is assured.

6.4.2. A direct question should follow. Studies show that people will disclose more often if asked directly. Remember if medical nursing staff are not able to speak directly about this issue, then neither will the patient.

6.4.3. Staff are encouraged to remember that success is asking the screening question in a safe way, no matter what the response or what help is accepted by the patient. This sends a strong message to the patient that domestic abuse is serious. Just asking may change the patient's thinking about what is happening to them. It also sends the message that there is help available. The patient may not accept help on the day but may keep the local resource numbers and call for help in the future.

Below are some examples of screening questions staff should use.

If staff are unable to ask the screening question, the reason why MUST be recorded in the patient record.

Examples of Framing the Question:

- All patients are now being asked if they have experienced any abuse or violence in their adult lives. This is a major health issue as we now know that up to 1 in 4 women and up to 1 in 6 men suffer domestic abuse at home in their lifetime.
- You may have seen the posters and leaflets outside about domestic abuse. We are asking all patients if this is something they are concerned about.
- In addition to your health concerns, we are also asking patients about the possibility of domestic abuse within the home.
- As domestic abuse in the home is so common we now ask all patients about it routinely.

Examples of asking a Direct Question:

- Do you feel safe at home?
- Do you ever feel frightened of your partner? Do you feel that you are in danger?
- Have you been physically hurt by your partner? Has your partner ever threatened to hurt you or someone you care about?
- I notice that you have a number of bruises. Could you tell me how they happened? Did someone do this to you?
- You seem anxious of your partner; do they ever lose their temper with you or try to control you?
- Do you ever feel controlled and isolated by your partner?
- Has your partner ever:
    - Destroyed or broken things you care about?
    - Threatened or hurt your children?
    - Forced sex on you, or made you have sex in a way that you did not want?
- Does your partner get jealous of you seeing friends, talking to people or going out? If so, what happens?
- Your partner seems very concerned and anxious about you? Sometimes people react like that when they feel guilty. Were they responsible for your injuries?
- Does your partner use drugs or alcohol excessively? If so, how do they behave

at this time?

6.5. Northern Devon Healthcare Trust employs Health IDVAs who are able to offer advice and support to patients who are experiencing or have experienced domestic abuse. The Health IDVA Service is able to work with patients who are in a relationship, who are thinking of separating or who have separated from partners (both same sex and opposite sex); as well as patients who are experiencing abuse from a family member.

7. Police Reports VISTAS

7.1. The purpose of VISTAS is to share information amongst relevant agencies. On receipt these are sent out to the relevant health practitioners. This ensures that information is shared to enable practitioners to offer support as necessary according to professional judgement.

8. Multi-Agency Risk Assessment Conference (MARAC)

8.1. Domestic abuse incidents that are identified and assessed as being 'very high risk' (i.e. at risk of imminent serious harm or death, using the Co-ordinated Action Against Domestic Abuse – Domestic Abuse Stalking and Harassment [CAADA-DASH]) risk identification tool will be addressed through Multi-Agency Risk Assessment Conferences (MARAC) that are held on a monthly basis.

8.2. Any agency that uses the CAADA-DASH Risk Identification Checklist as a risk assessment tool will refer to MARAC if they assess a person to be at high risk. The intended outcome of MARAC following risk identification is to:

- Draw up a multi-agency action plan
- Reduce risk
- Monitor and review

8.3. A number of agencies are represented at MARAC including health. The health practitioner attending MARAC will receive a list of cases to be discussed at the MARAC meeting before that meeting. The MARAC health representative is responsible for assessing appropriate information about those cases prior to the meeting and for feeding information from the meeting to the relevant health practitioners. Health professionals can refer cases to the MARAC process as required (see Appendix B: Health Professionals' Role in MARAC).

8.4. A staff member from ED and/or the hospital Health IDVAs attend MARAC.

8.5. If a person is referred to MARAC, it is not necessary to obtain consent to share relevant and proportional information about the person, with the aim of reducing the risk of imminent serious harm or death. It is best practice that consent should be sought, but if a practitioner is unable to, or believes that this may put the person at higher risk, the information should be shared regardless.

8.6. Please note that if a person with children is referred to MARAC, a MASH referral for the child(ren) must also be made (because they are living in a household where somebody is deemed to be at risk of imminent serious harm or death).

8.7. The combined MARAC and MASH referral (along with guidance) is available at:

https://new.devon.gov.uk/dsva/information-for-professionals/marac/#anchor1

9. What to do if a disclosure is made

9.1. The aim of staff is to support a person subjected to domestic abuse through the process of seeking advice by the use of signposting to appropriate agencies (See appendix D)

9.2. Explain that there are specialist domestic abuse workers available who offer a confidential, non-judgemental and independent support service.

- If the client consents to a referral, a referral can be made as follows
  - By telephoning the Health IDVA service
  - By completing a referral form and emailing it to the Health IDVA service
  - By completing a referral form and faxing it to the Health IDVA service
- It is important that you obtain a **safe** contact/email address for the patient. It may be that it is only safe to call at certain times and this can be facilitated (if the Health IDVAs have this information).
- Alternatively a client may just want to take the Health IDVA's contact details to call in their own time rather than giving over their contact details.

(See appendix A)

9.3. A key feature of the Health IDVA service is that it is externally managed by a specialist domestic abuse organisation. Best practice dictates that IDVAs are independent from organisations such as police, social services and health to enable anyone that that they are working with to feel comfortable disclosing to and being supported by the IDVA practitioner. This ensures that the focus of the work is on the reduction of risk to the client and any children are involved.

9.4. Support that the IDVA service is able to offer includes:

- Safety planning, including assessing police safety options
- Increasing patients' awareness of what is abusive behaviour
- Multi-agency risk management (if assessed as high risk)
- Practical support
- Access to a counselling service and group work programmes, including Pattern Changing
- Advocacy
- Sign-posting to other services if appropriate
- Emotional support
- Access to emergency accommodation

9.5. If a child or vulnerable adult (who lacks capacity) is involved then, as stated above, a professional judgement should be made as to whether the threshold for enquiry to MASH or to the social care vulnerable adult coordinator is reached.

9.6. Advice and support for staff dealing with cases of domestic abuse is through the Health IDVA Service, Named Nurse or Midwife for Safeguarding, Vulnerable Adult Lead or Line Managers.

10. Documentation

10.1. Recording of domestic abuse should be carried out in a careful manner.

10.2. All healthcare professional bodies have guidelines/codes of conduct that state the need for healthcare professionals to protect all confidential information and disclosures should only be made with consent or where required by order of a Court where there is justified disclosure in the wider public interest.

10.3. Confidentiality is essential in enabling a person subjected to domestic abuse to disclose their experience and indeed their physical safety can depend on confidentiality being maintained.

10.4. Incidents or reports of domestic abuse should not be documented in any hand held records in case these are accessed by the perpetrator.

10.5. It is vital to ensure concise record keeping and documentation is maintained in order that healthcare professionals can respond appropriately. The healthcare worker must ensure that care is taken to monitor confidentiality in order to protect the abused person from further violence. Therefore, records of domestic abuse should be held separately from records (i.e. not in the personal maternity record/hand held notes), which may be seen by the perpetrator.

10.6. It is important that patients are aware that disclosures will be documented.

10.7. Confidentiality must be discussed with the abused person to ensure that they are clear about the limits to confidentiality (confidentiality may be broken if a worker is concerned that a child or vulnerable adult is at risk of harm or if the patient is assessed to be high risk of domestic abuse).

10.8. Photographic evidence should be taken as required by a police photographer.

Records may be used:

10.8.1. In evidence particularly in cases where perpetrators of domestic abuse are being charged with assault.

10.8.2. To help the abused person to obtain an injunction or court order for protection.

10.8.3. By family courts to assess risks to children when there are issues of granting access.

10.8.4. To help the abused person obtain a “homeless due to domestic abuse” status.

11. Staff Training

11.1. Domestic violence and abuse are all included in Level 3 Safeguarding Children and adult training and can be booked via STAR.

11.2. The Devon Children and Family Partnership (DFCP) provide domestic abuse specific training and should be booked through the DSCB website: http://www.devonsafeguardingchildren.org

11.3. Training can be recording on the Safeguarding Training Declaration.

12. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

Key performance indicators comprise:

- Key performance indicators comprise following this policy at each step with evidence of appropriate actions documented in the patients records.

Process for Implementation and Monitoring Compliance and Effectiveness

Process for Implementation and Monitoring Compliance and Effectiveness

- The health IDVA should provide a bi-annual audit of the referrals from NDHT and Contact Summary Report (SafeLives Insights Data Report) to the Safeguarding Children Team. The safeguarding Children Team will undertake 'dip sample audit' of the domestic abuse questions in ED and Maternity. Audit and report results will be reported to the NDHT Safeguarding Children Operational Group. Issues with following the policy will be taken to the NDHT Safeguarding Children Operational Group and then on the NDHT Safeguarding Children and Adult Board.

13. Equality Impact Assessment

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age	x			
Disability	x			
Gender			x	
Gender Reassignment			x	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership	x			
Pregnancy	x			
Maternity and Breastfeeding	x			
Race (ethnic origin)			x	
Religion (or belief)			x	
Sexual Orientation			x	

14. References

- Department of Health (2000) Domestic Violence; A resource manual for healthcare professionals
- Department of Health (2005) Responding to domestic abuse: a handbook for health professionals.
- The Home Office (2004) Development and Practice Report. Safety and Justice: sharing personal information in the context of domestic violence and overview.
- The Home Office (2005) Domestic Violence; a national report

15. Associated Documentation

- Safeguarding Children Policy
- Safeguarding Adult Policy
- Healthcare Records Policy
- Lone Working Policy
- Managing Violence and Aggression Policy
- Routine Antenatal and Booking Guidelines
- Incident Management and Investigation Policy

Appendix A: Actions to be taken by health staff with suspected cases of Domestic Violence and Abuse

- Explain that there are specialist domestic abuse workers available who offer a confidential, non-judgemental and independent support service.
- If the client consents to a referral, a referral can be made as follows:
  - By telephoning the Health IDVA service; Vicky Hemmingway, SPLITZ, NDADA
  - By completing a referral form (see below) and emailing it to the Health IDVA Service at vickyhemmingway@nhs.net
  - By completing a referral form and faxing it to the Health IDVA Service via the **A&E fax machine on 01271 349106**
- It is important you obtain a **safe** contact number/email address for the patient. It may be that it is only safe to call at certain times and this can be facilitated (if the Health IDVAs have the information).
- Alternatively a client may just want to take the Health IDVA contact details to call in their own time rather than giving over their contact details.

Please note that the Health IDVA Service is only available on weekdays from 9am – 5pm (4:30pm on Fridays).

If a client discloses that they are unsafe to return home out of hours the following numbers may be useful:

- Women's Aid 24 Hour Helpline (can offer advice and support as well as contact details for refuges with spaces): **0808 2000 247**
- Emergency out of hours service (social care for children and adults): **0845 6000 388**
- Emergency housing out of hours: **01271 388240**

If a crime has been committed the Police can be contacted on 101. If you have any concerns that someone is at risk of imminent harm then the Police should be contacted on **999.**

If you suspect that there is a child at risk then a MASH (Multi Agency Safeguarding Hub) enquiry must be made, even if the client does not consent to this.

If you suspect that a vulnerable adult is at risk then a referral must be made to adult social care via CareDirect.

Please see below referral form.

Domestic Violence Health Project
North Devon District Hospital, Barnstaple
Domestic Abuse Referral Form

PATIENT DETAILS:	WHO IS MAKING THE REFERRAL?
Patient Name……	Date……
Patient DOB……	Name……
Gender……M……F……	Position……
	Contact Number……

CONTACT WITH HEALTH IDVA:

☐ **Positive disclosure but no contact/support wanted currently. (Info only)**

☐ **IMMEDIATELY……Phone Vicky 07581 629498 (Mon to Friday) or 01271 370080**

☐ **Wants to contact Health IDVA themselves……Give IDVA contact details**

☐ **Wants Health IDVA to contact them……Take SAFE telephone contact number and safe contact times**

SAFE Contact Number……

SAFE Contact Times……

PATIENT INFORMATION

Ethnic Origin……

Fluent English…..Y……..N……

Language Needs……

No of Children……

Ages of Children……

Pregnant……Y……..N……

Due Date……

Disabilities……

Alcohol/Drug Issues…..Y…..N……..

Mental Health Issues…Y…..N……..

Any risk assessment notes……

……

……

DETAILS OF ABUSE

☐ Physical

☐ Sexual

☐ Emotional

☐ Financial

☐ Other – please state

☐ Often

☐ Occasional

☐ Throughout Relationship

☐ Recent only

☐ Previous abusive relationships – please state how many……

How many times has the patient been to the hospital for domestic abuse related symptoms/injuries?

……

……

PERPETRATOR

☐ Male

☐ Female

☐ Current Spouse

☐ Ex-Spouse

☐ Current Partner

☐ Ex-Partner

☐ Other – please state

……

☐ Currently living with perpetrator

☐ Living apart from perpetrator

☐ Has got a criminal record

☐ Any Police involvement

☐ Threatens to kill

☐ Controlling behaviour

☐ Stalking

☐ Uses/Has used weapons

CURRENT INJURIES CAUSED BY THIS PERPETRATOR

TYPE OF INJURY	SITE OF INJURY	REPORTED CAUSE OF INJURY
……	……	……

Appendix B: Health Professionals' Role in MARAC

At Northern Devon Healthcare Trust a representative from the Emergency Department or the IDVA attends the MARAC but any Health professional can refer cases to the MARAC process if they have assessed the patient as high risk using the CAADA-DASH risk identification form. The referral form (and guidance) can be found at: https://new.devon.gov.uk/dsva/information-for-professionals/marac/#anchor1

Health professional receives notification of patient being discussed at forthcoming MARAC meeting, from the MARAC health representative.

Health professional provides information to the health representative attending MARAC. Information required includes: contact with child and family, identification of protective factors

On receipt of the information from the MARAC the health professional will: review the health record, in light of the MARAC information, establish the role of health professional according to multi-agency plan, review any risk to self and other staff members, health professionals to make judgement whether to visit the patient and child according to identified health needs, providing any actions does not compromise their safety. They may seek advice from Safeguarding Team as necessary. They should document discussion/actions on health record

Following the MARAC meeting, the health representative attending MARAC will feed-back to the relevant health professional(s) any actions that have come out of MARAC. They will then feed-back to the MARAC administrator when these actions have been completed.

Appendix C: Recognition of domestic abuse and barriers to leaving an abusive relationship and seeking help and support

There are a number of recognised physical, emotional and behavioural signs/symptoms that can raise concern that a patient may be experiencing domestic abuse. None of the signs automatically indicate domestic abuse but they should raise suspicion and prompt you to make every attempt to see the patient alone in private to ask them if they are experiencing domestic abuse. Even if they choose not to disclose at this time, they will know you are aware of the issues and they might choose to approach you, or another health professional at a later time. If you are going to ask a patient about domestic abuse always follow NDHT Domestic Violence and Abuse Policy.

Possible Signs of Domestic Abuse:

- Frequent appointments for vague symptoms
- Injuries inconsistent with explanation of cause
- Patient tries to hide injuries or minimise their extent
- Partner always attends unnecessarily
- Patient is reluctant to speak in front of partner
- Suicide attempts
- History of repeated miscarriages, terminations, still births or pre-term labour
- Repeat presentation with depression, anxiety, self-harm or psychosomatic symptoms
- Sexually transmitted diseases and frequent vaginal or urinary tract infections
- Non-compliance with treatment
- Frequently misses appointments
- Multiple injuries at different stages of healing, especially to the neck, head, breast, abdomen or genitals
- Patient appears frightened, overly anxious or depressed
- Partner is aggressive or dominant, talks for a patient or refuses to leave the room
- Patient is submissive or afraid to speak in front of their partner, constant presence of partner at examinations
- Late booking in pregnancy. Poor or non-attendance at ante-natal clinics
- Frequent use of minor tranquillisers
- Early self-discharge from hospital

In addition to the above, many health care professionals have an on-going relationship with women who are on their caseload. As a result they may identify or observe additional indicators. These could include:

- A deterioration in the physical appearance of a patient (this may become apparent over a period of time).
- Uncharacteristic requests for money and/or items of food, clothing etc.
- A deterioration in the general health of a patient (again, this may become apparent over a period of time).
- Continuous presence of a partner at the surgery, clinic or home appointments

Possible Presenting Complaints:

- 'Falls'
- Complains of abuse directly
- Chronic pain syndrome, headaches
- 'Stranger' assault
- Anxiety, depression, multiple somatic complaints
- Overdoses/suicide attempts or ideation
- Psychosomatic complaints
- Miscarriage/vague gynaecological complaints (e.g. pelvic pain)

Possible Indicators of Abuse from Patient's History:

- Delay in seeking care
- Injuries inconsistent with explanation of cause
- Partner always accompanies patient for no apparent reason
- Early self-discharge from hospital
- History of children being abused
- 'Accident prone' patient
- Frequent walk in centre visits
- High stress in family (financial worries, pregnancy, relocation, change or loss of job, bereavement)
- Drug/alcoholism

Possible Behavioural Indicators of Abuse

- Obsessive compulsive disorder
- Suicide attempts
- Patient embarrassed, poor eye contact
- Patient evasive/guarded
- Patient denies abuse too strongly
- Patient depressed with injuries
- Patient defers to partner
- Patient has fearful behaviour with partner
- Patient minimises injury or demonstrates inappropriate responses

High Risk Injuries

- Mid arm injuries (defensive)
- Strangulation marks
- Injuries to areas not prone to injury by falls
- Weapon injuries or marks
- Symmetrical injuries
- Old as well as new injuries
- Bites and burns (scald and cigarette)
- Injuries to multiple sites
- Poor nutrition

Common Injuries

- Dental injuries

- Black eyes
- Breast/abdominal injuries
- Mid face injuries
- Internal injuries
- Injuries hidden by clothing

Intimate Partner Domestic Abuse and Health

- Domestic violence and abuse has health related consequences that extend beyond the immediate injuries from physical assault
- Survivors of domestic abuse are more likely to be in contact with health professionals that any other service (Pahl 1995)
- 35% of women attending the accident and emergency departments have experienced domestic abuse and a 1997 study found that only 6% of women were assessed for abuse (Jezierski 1994, Warshaws 1989)
- 1 in 9 women experience domestic abuse where medical attention is needed (Shanko 1998)
- One woman is murdered every three days in the UK as a result of domestic abuse (Home Office)
- Women will, on average, experience 35 episodes of abuse before seeking help (Jaffe 1982)
- Twice as many women approach GP's and Health Visitors as approach the Police (Dominy and Radford)
- Domestic abuse is five times more prevalent than what is indicated in medical case notes (Mezey and Bervely 1999)

Barriers to Leaving an Abusive Relationship

Fear

- Destroy belongings or the home
- More abuse or severe abuse
- Harm to their job or reputation
- Have them arrested or charged with a crime
- Harm to their children, pets, family or friends
- Take the children
- Of losing custody of their children
- Of being charged with kidnapping if she/he takes their children away
- Of retaliation on them, family, friends and /or those who help them
- Of Court involvement
- That their partner is able to survive without them

Resources

- Lack of social support
- Lack of support from institutions
- Lack of housing alternative
- Lack of money
- Does not want to leave their home, belongings or community

Beliefs

- That the violence is temporary or caused by unusual circumstances
- That the children need to be raised in a two parent home

- That the abuse stems from alcoholism, stress of lack of spirituality
- That a perpetrator intervention programme (violence prevention programmes) as ones in probation can 'fix' him/her
- That all men/women are violent and that violence should be expected in a relationship
- That divorce or separation is wrong
- That they can stop the violence

Pressures

- Cultural and religious constraints to remain in marriage
- Guilt about the failure of her/his relationship
- Unaware that domestic abuse is a crime
- Love for the perpetrator
- Feelings of a personal incompetence

Concerns about Seeking Help

- Concern about how to communicate with the worker; the survivor may be so overwhelmed by all of what is going on in their life that in anticipating talking with you she/he may worry about what to say. They may be worried that you will use what they tell you to hurt them or their children.
- Fear of being judged or viewed as less than human
- The survivor may be concerned that you will judge them harshly because they need help and is embarrassed about what has happened to them. This is probably the response they have received from others and has internalised those views. They view themselves in a negative way because they need help.

Concerned about Confidentiality

The survivor may be concerned with confidentiality for many reasons. They may be concerned that other agencies will be aware of their personal information or that information will get out and, in particular, back to the perpetrator.

Concern about being pressured

They may fear that you will pressure or make them do something that they do not want to do. They may fear that we will be pressured to make a decision that they are not sure they can comply with.

Concern about Negative Consequences of seeking Help

They may be concerned with the negative consequences from the perpetrator who is likely to have warned them of what he/she will do to them or others if they seek help. They may know that the abuse will carry out these threats by times in the past when they have sought help from other sources. They may be operating under false presumptions about the kind of help you offer.

Paternal Filicide in the context of Domestic Abuse:

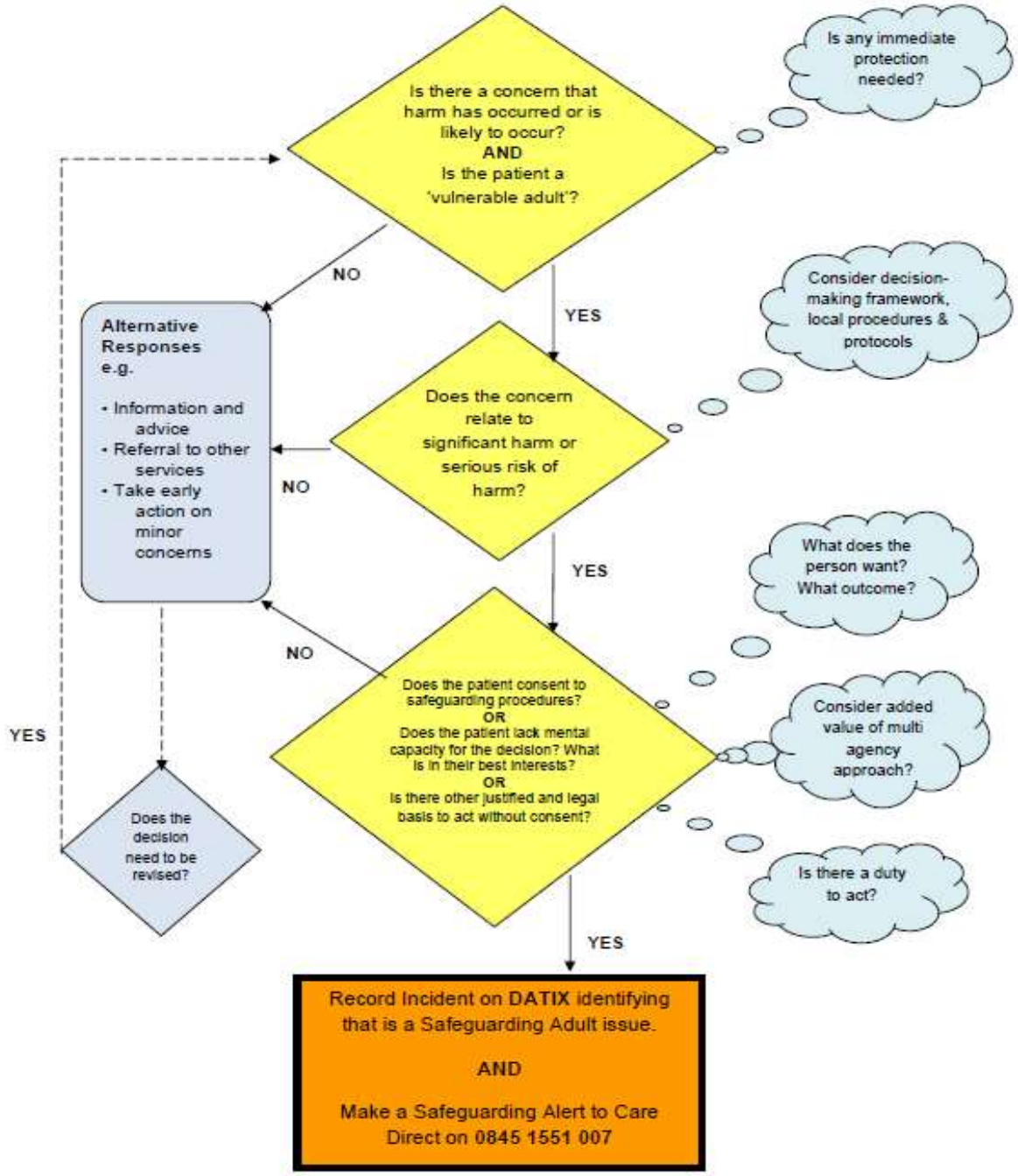
Paternal filicide, where a child is killed by their parent, in the context of domestic abuse is a rare event that is often hard to predict and prevent. However, the results from current research with domestic homicide review committees suggest that warning signs may be overlooked by some professionals and agencies that do not foresee the direct harm to children. Even in cases where the danger to adult victims was recognised, the potential harm to the children was not seen. Child homicides in the context of domestic abuse are often motivated by revenge against the mother for leaving the abusive relationship. The findings suggest that adult homicides and child homicides, which take place in the context of domestic violence, have similar warning signs. There is a need for close coordination among family and criminal courts, professionals to ensure that the safety plan for a parent in these circumstances extends to the children as well.

Key practice messages from research are:

- Paternal filicide is a rare event that is often hard to predict and prevent.
- Current research with domestic homicide review committees suggests that warning signs may be overlooked by some professionals and agencies that do not foresee the direct harm to children.
- Child homicides in the context of domestic violence are often motivated by revenge against the mother for leaving the abusive relationship.
- There is a need for close coordination between multi-agency professionals to ensure that the safety plan for a parent in these circumstances extends to the children as well.

Ref: Jaffe, P. Campbell, L. Olszowy, L. Hazel, A Hamilton, Child Abuse Review Vol. 23: 142–153 (2014)

Appendix D: Decision and reporting process for safeguarding adult concerns, key decisions for safeguarding adults



Vulnerable Adult

A "vulnerable adult" is a person *"who is or may be in need of community care services by reason of mental or other disability, age or illness,* ***and*** *who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".*

Abuse

Abuse is a violation of an individual's human and civil rights by any other person or persons. Abuse may be perpetrated as the result of deliberate intent, negligence or ignorance.

Types of Abuse

Physical Abuse

Including hitting, slapping, pushing, kicking, misuse of medication or inappropriate sanctions or restraint

Sexual Abuse

Including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent or was pressured in to consenting

Psychological Abuse

Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation or blaming

Financial or Material Abuse

Including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions or the misuse or misappropriation of property, possessions or benefits

Neglect and Acts of Omission

Including ignoring medical or physical care needs, failure to provide access to appropriate health, social care, or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

Discriminatory Abuse

Including abuse motivated by discriminatory and oppressive attitudes towards race, gender, cultural background, religion, physical and/or sensory impairment, sexual orientation and age. Discriminatory abuse manifests itself as physical abuse/assault, sexual abuse/assault, financial abuse/theft and the like, neglect and psychological abuse/harassment, including verbal abuse

Institutional Abuse, Neglect and Poor Professional Practice

Including abuse that takes the form of isolated incidents of poor or unsatisfactory professional practice at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other

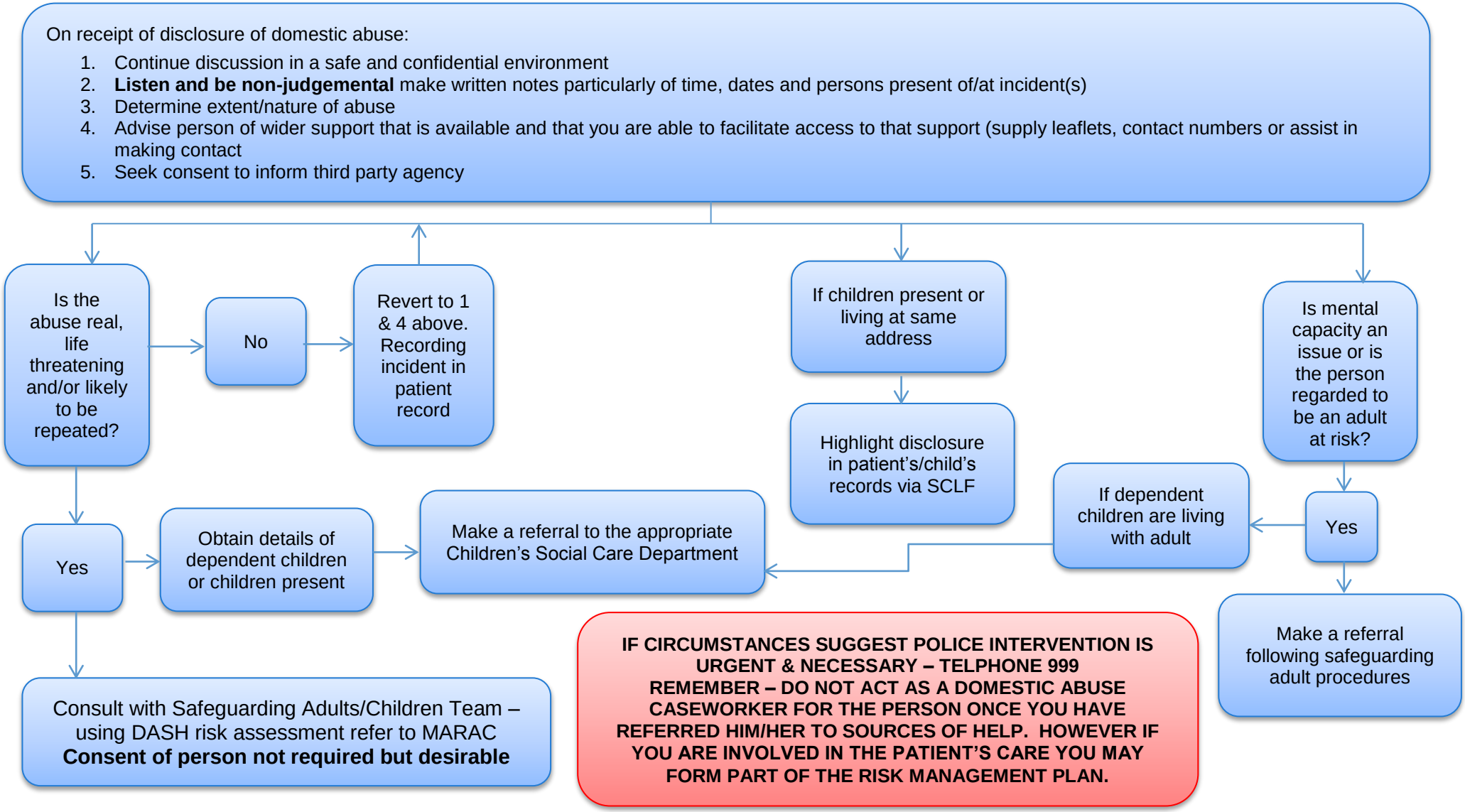
Significant Harm and Serious Exploitation

'Any ill treatment that leads to the impairment of or avoidable deterioration in the individual's physical or mental health, or the impairment of or avoidable deterioration in physical, intellectual emotional social or behavioural development'.

Key Contacts for Safeguarding Adults

Care Direct – for raising safeguarding alerts – 0845 1551 007
Police – if at risk of immediate danger – 999
Police Central Referral Team – non emergency crime – 0845 6051 166
Devon County Council Safeguarding Team – for advice and support – 01392 32339
NDHT Safeguarding Adult Lead (Leigh Skelton) – for internal advice/support; and any safeguarding adults

Appendix E: Domestic Abuse Flowchart – Children



Appendix F: Risk Identification Checklist

CAADA Risk Identification Checklist (RIC) & Quick Start Guidance for Domestic Abuse, Stalking and 'Honour'-Based Violence

You may be looking at this checklist because you are working in a professional capacity with a victim of domestic abuse. These notes are to help you understand the significance of the questions on the checklist. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also be used for lesbian, gay, bisexual relationships and for situations of 'honour'-based violence or family violence. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

✓ The purpose of the RIC is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

✓ The RIC should be introduced to the victim within the framework of your agency's:

- Confidentiality Policy
- Information Sharing Policy and Protocols
- MARAC Referral Policies and Protocols

✓ Before you begin to ask the questions in the RIC:

- Establish how much time the victim has to talk to you? Is it safe to talk now? What are safe contact details?
- Establish the whereabouts of the perpetrator and children;
- Explain why you are asking these questions and how it relates to the MARAC

✓ Whilst you are asking the questions in the RIC:

- Identify early on who the victim is frightened of – ex-partner/partner/family member
- Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.

- ✓ Revealing the results of the RIC to the victim: Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to MARAC and children's Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.

- ✓ Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

The responsibility for identifying your local referral threshold rests with your local MARAC and currently sits at 14 "yes" answers.

Resources:

- ✓ Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following websites and contact details may useful to you:

National Agencies:

- National Domestic Violence Helpline - 0808 2000 247 - for assistance with refuge accommodation and advice.
- Women's Aid website: www.womensaid.org.uk – large range of information for people experiencing domestic abuse and professionals working with them including a "survivor's pack".
- Honour' Network Helpline - 0800 5999247 - For advice on forced marriage and 'honour' based violence (for people experiencing so-called "honour"-based violence and professionals working with them.
- Karma Nirvana website: http://www.karmanirvana.org.uk and Iranian and Kurdish Women's Rights Organisation and ikwro.org.uk/ - both offer information and advice for people experiencing so-called "honour"-based violence and professionals working with them.
- Broken Rainbow - 08452 604460 – www.broken-rainbow.org.uk for advice for LGBT victims
- Mankind - 01823 334244 – national helpline for men experiencing domestic abuse. Website: www.mankind.org.uk

Local Organisations

Northern Devon Healthcare Trust Health IDVAs –

All patients who disclose that they are (or have been) experiencing domestic abuse are referred to the Health IDVA's, who are externally managed by North Devon against Domestic Abuse and part of the local domestic abuse network.

As well as offering direct support to the patient, the Health IDVA's may refer the patient to local organisations to deal with other issues e.g. drug/alcohol use, mental health etc.

North Devon against Domestic Abuse also offers counselling and group-work programmes which the Health IDVA's can refer patients to.

The Oak Centre –

01392 436967; Fax: 01392 428730; Email: ndht.OakCentreEnquiries@nhs.net

Sexual Assault Referral Centre for patients who have experienced rape and/or sexual assault Devon-wide.

Devon Rape Crisis Centre –

01392 204174 - Information and support for people who have experienced rape, sexual assault or childhood sexual abuse