DOMESTIC ABUSE POLICY (PATIENTS)

POLICY

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	x		
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1.0 INTRODUCTION

This policy is intended to raise awareness of Domestic Violence & Abuse (DV&A) as a serious healthcare issue ensuring that the response by Sherwood Forest Hospital NHS Foundation Trust to Domestic Abuse supports our patients, families and carers. It also includes employees, perpetrators and those in the care of our services and seeks to maintain and enhance public confidence.

There is a requirement for all NHS Trusts to have a Domestic Abuse policy in line with the principles of The National Public Health Outcomes Framework for England (2019-2022) and NICE Quality Standard Domestic Violence and Abuse (QS116) 2016.

This policy sets out a consistent and effective response by Sherwood Forest Hospital NHS Foundation Trust to the Government's drive in tackling domestic violence and abuse in recognising that the NHS has a particular contribution to make as it is the one service that almost all survivors of Domestic Violence and Abuse will encounter at some point in their lives. (Violence against Women and Girls 2016-2020 Department of Health, FGM: Mandatory reporting in healthcare (2015) Department of Health, NICE Quality Standard Domestic Violence and Abuse (QS116) 2016, Public Health Outcomes Framework 2019-2022Department of Health)

Sherwood Forest Hospitals NHS Foundation Trust (The Trust) will work in partnership with agencies in addressing domestic Violence and abuse (DV&A) against adults and children. The Trust recognises that domestic abuse is a significant concern when considering the health and well-being of women, children and men who present for care at the Trust. It is therefore committed to providing safe and effective care which includes referral to specialist support services.

Domestic Abuse is identified as a major public health issue, impacting on survivors and their children and families' physical and emotional health and well-being and may also include homelessness, loss of income/work, isolation, poverty and financial hardship (NICE 2015). Early intervention can reduce the many consequences of domestic violence and abuse (Violence against Women and Girls 2016-2020 Department of Health).

Approximately 75% of children living in households where domestic and sexual violence and abuse occurs are exposed to actual incidents. These children have an increased risk of developing acute and long term physical and emotional health concerns with an associated increased risk of abuse, death and serious injury (NSPCC, Radford et al 2011). Within this context Sherwood Forest Hospitals NHS Foundation Trust recognises its responsibilities to safeguard and protect children.

- 8% of maternity patients will experience DV&A
- 69% of women and 49% of men with severe mental illness in mental health services will experience DV&A
- 12.5% of suicides and suicide attempts by women in the UK are due to domestic abuse
- Of all the children and young people who died by suicide under the ages of 20 years, 19% witnessed DV&A
- 40-62% of women in substance abuse services have experienced DV&A
- (Domestic Abuse and Violence update 2019 Annual Report NHSE)

Extrapolations from the Crime Survey indicate that around 5.5% of adults (46,480 people) are likely to have experienced domestic abuse in Nottinghamshire within the last year, while around 176,400 are likely to have experienced some form of domestic abuse in their lifetime. (Nottinghamshire Police & Crime Commissioner 2020)

Domestic abuse occurs across all sections of society and this policy reflects that men are victims as well as women but recognises that men are far more likely to be the perpetrators and women the victims (Violence against Women and Girls 2016-2020 Department of Health). Women are also more likely to experience repeated and severe forms of violence, including sexual violence and are also more likely to have sustained psychological or emotional impact or result in injury or death (Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08).

It is important to acknowledge that lesbian, gay and transgender relationships are also affected by domestic abuse. There may be additional issues or barriers which occur within same sex relationships, and it is important to recognise it merits the same level of concern and the same professional, supportive response from the health service (Department of Health, 2005).

This policy is not a replacement for one-to-one discussion, support or supervision with the professional's immediate manager or with the Trust Safeguarding Team where concerns exist about the welfare of an adult or child.

Domestic Violence and Abuse is not only an issue for service users. There is a need to address Domestic Violence and Abuse for employees, male or female when they themselves may be current or past survivors of Domestic Violence and Abuse or are perpetrators of violence and abuse.

The Trust acknowledges that Domestic Violence and Abuse will impact upon the health and wellbeing of its employees and in addition may affect their performance at work and seeks to offer support and assistance (refer to Sherwood Forest Hospital Foundation Trust Staff Workforce Domestic Abuse policy).

2.0 POLICY STATEMENT

The Trust is committed to promoting best practice in recognising and responding to domestic abuse. The policy also sets out the responsibilities and expectations of all clinical staff to recognise and respond to victims of domestic abuse, to undertake a robust risk assessment (DASH – Domestic Abuse Stalking and Harassment), to support a victim in accessing support, to identify high risk victims and support the purpose of MARAC (Multi Agency Risk Assessment Conference) and safety plans, as well as sharing information with partner agencies to best protect adults and/or children from serious harm.

This clinical document applies to:

Staff groups

- Nursing, midwifery, allied health professionals' therapy and medical
- All clinical staff caring for patients (adults and/or children) where there are concerns or a disclosure of domestic abuse

Clinical areas

- All clinical areas within the Trust

Patient groups

- All patients (adults and children) presenting to the Trust who are experiencing domestic abuse or where there are concerns

Exclusions

- No exclusions

3.0 DEFINITIONS/ ABBREVIATIONS

Domestic Abuse (Violence):
The Governmental definition of Domestic Abuse was amended in 2013 to include psychological intimidation and controlling or coercive behaviour and to include those aged 16 years and over.

'Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*

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 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 their victim.'**

*This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Stalking and harassment
Stalking involves a person becoming fixated or obsessed with another. It is a pattern of persistent and unwanted attention that may make you feel scared, anxious or harassed. Some examples of stalking:

- Regularly giving unwanted gifts
- Making unwanted communication
- Damaging property
- Repeatedly following you spying on you
- Threats

- **For types and descriptions of the types of abuse see Appendix A**
- **For potential indicators of abuse in adults/ potential impact of abuse on children see Appendix B(i) and Appendix B(ii)**

Trust	Sherwood Forest Hospitals NHS Foundation Trust (SFHFT)
Staff	All employees of the Trust including those managed by a third party on behalf of the Trust
Victim / Survivor	The term 'victim' is often perceived as negative. A survivor of domestic violence and abuse is anyone who has been injured or emotionally or sexually abused by a person with whom she/he has had an intimate partner or family member relationship with.

Child/Young Person	Anyone under the age of 18 years.
Honour Based Violence	*A crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community'. Court Prosecution Service (CPS) and Association of Chief Police Officers (ACPO) definition.* It is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceived that a relative has shamed the family and/or community by breaking their honour code. Honour based violence can be distinguished between other forms of violence and it is often committed with some degree of approval and/or collusion from family and/or community members
Female Genital Mutilation (FGM)	Female Genital Mutilation also known as female genital cutting and female circumcision, is defined by the World Health Organization (WHO) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons'' FGM is practised as a cultural ritual in 28 countries in Sub-Saharan and North-Eastern Africa; it is also found in parts of Asia, the Middle East and within immigrant communities elsewhere including European countries, England and Wales
Forced Marriage	A forced marriage is where one or both people do not (or in cases of people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they are bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.
Think Family	Think Family approach helps to provide responses to the most vulnerable families and reduce inter-generational cycles of poor outcomes. Utilising a 'Think Family' approach ensures services work more cohesively in meeting the needs of a family as a unit, not with individuals in isolation.
Trilogy of Risk	Used to describe the overlapping issues of domestic violence, parental mental ill-health and substance misuse which have been identified as common features of families where harm to women and children has occurred. These are viewed as indicators of increased risk of harm to children and young people
DASH – RIC	Domestic Abuse Stalking and Harassment - Risk Indication Checklist. A simple tool for practitioners to use to assess level of risk when working with survivors of domestic violence and abuse to help identify high risk cases in the community and within services
MARAC	Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, co-ordinated safety plan is formulated to support the survivor.
MAPPA	Multi Agency Public Protection Arrangements is the name given to arrangements in England and Wales for the 'responsible authorities' tasked with the management of registered sex offenders, violent and other types of offenders who pose a serious risk of harm to the public.
Routine Enquiry	Asking all people who access services about their experiences, if any, of domestic violence or abuse, regardless of whether there are indicators of abuse or violence is suspected.

Selective Enquiry	Asking people who access services directly about their experiences, if any, of domestic violence or abuse where there are suspicions or concerns, including the presence of indicators of abuse.
Stalking	"Two or more incidents (causing distress, fear or alarm) of obscene or threatening unwanted letter or phone call, waiting or loitering around home or workplace, following or watching, or interfering with or damaging personal property by any person, including a partner or family member"
Disclosure	For the purpose of this guidance, disclosure is defined as any occasion when an adult or child who has experienced domestic violence or abuse informs a health care professional.
Care Act (2014) identifies domestic abuse as a new category of adult abuse.	The Care Act (2014) identifies everyone is entitled to live their life in safety without being mistreated, hurt or exploited by others. But some people's situations may make them less able to protect themselves from harm or mistreatment. An adult at risk is aged **18 years** or over: *NOTE- The definition of Domestic abuse is any person from the age of **16 years**.* An adult at risk may be a person who: • Is elderly and frail due to ill health • Has a learning disability • Has a physical disability and / or a sensory impairment • Has mental health needs including dementia or personality disorder • Has a long -term illness /or condition • Misuses substances or alcohol • Is unable to make their own decisions due to lack of capacity and is in need of care and support. • **Is a young adult, over the age of 18, who has care and support needs and is 'in transition' from children's' to adults' services or** is a Carer (looking after another person with care and support needs This list is not exhaustive, other people might also be considered to be adults at risk
Assessor	A person undertaking the initial assessment in the clinical environment where the patient has presented or is being admitted.

Abbreviations

- **PPU** – Public Protection Unit
- **IDVA** – Independent Domestic Violence Advocate
- **MARAC** – Multi Agency RISK Assessment Conference
- **ED** – Emergency Department
- **UCC**-Urgent Care Centre
- **HVSU** – High volume service user
- **MDT** – Multi Disciplinary Team
- **MIU** – Minor Injury Unit Newark
- **MASH** – Multi Agency Safeguarding Hub
- **DASH** – Domestic Abuse Stalking and Harassment Risk Assessment.
- **DPA** – Data Protection Act

- **DALT**–Drug and Alcohol Liaison Team
- **NIDAS** – Nottinghamshire Independent Domestic Abuse Service
- **Equation** – Is a registered charity who support male survivors of Domestic Abuse.
- **Exploitation** – is when one person uses another person for one's own gain. We say that exploitation happens when one person takes advantage of another person.
- **NWAL** – Nottinghamshire Women's Aid

4.0 ROLES AND RESPONSIBILITIES

4.1 Trust Board
Support the decision to impart information to other agencies provided that the risk to the individual or the public overrides the responsibility of confidentiality to the individual concerned.

4.2 Chief Executive
The Chief Executive has executive responsibility for Safeguarding (which includes domestic violence and abuse) and is ultimately responsible for ensuring that the Trust engages with information sharing to support the safety of victims and or children and meets its legal responsibilities in safeguarding adults (Care Act 2014) and/or children (Working Together 2018)

4.3 Information Governance Officer
To support the role of the Domestic Abuse Nurse to provide information, expertise and advice to the DASH process to enable robust risk assessments process to be carried out and information to be shared within the MARAC process.

4.4 Divisional Managers / Heads of Departments
Will ensure that relevant staff within their services are identified and adequately trained to undertake the roles required in responding appropriately to Domestic Abuse. To assist the quality improvement of embedding the recognition and response to domestic abuse and support access to training to ensure staff understand the risk assessment process (DASH).

4.5 Line Managers:
Line Managers have a responsibility to ensure that all staff reporting to them are familiar with their responsibilities, have attended a range of training activities appropriate to their responsibilities and that there are supported mechanisms agreed for staff who may have to participate in this process.

4.6 All Staff employed by Sherwood Forest Hospitals
It is the responsibility of every staff member to familiarise themselves with the Trust Policy for Domestic Abuse and related multi-agency guidance.

Will have a basic awareness of Domestic Abuse, the indicators of domestic abuse and what actions they should take.

All Trust staff working with individuals where there is a disclosure, or a concern of domestic abuse must consider the safeguarding needs of children or adults at risk that the individual may come into contact with.

Staff must assess these risks and make appropriate adult or child safeguarding referrals as per Trust Safeguarding policies and procedures.

4.7 Hospital Independent Domestic Violence Advisor (IDVA)

Provides information, expertise and advice to the Trust to develop and increase knowledge and organisational understanding of the links across safeguarding of children and adults living with domestic violence, and act as a source of specialist expertise to the organisation.

Offers support and advice to clinicians and other SFHFT staff to take appropriate action to prevent and reduce the risk to individuals of abuse.

Liaises with partner agencies to enable robust risk assessment and care planning for patients where there are concerns of domestic abuse.

Promotes and develops good professional practice throughout the Trust in staff recognising and responding to domestic abuse

Provides Domestic abuse and DASH risk assessment training

Receives complex, highly sensitive information from the health community, the Police and other agencies about very high-risk domestic abuse cases, and effectively communicate with SFHFT Multi-disciplinary Team (MDT)DT staff when appropriate and relevant to do so.

Provides a lead role and representation for Sherwood Forest Hospital NHS Foundation Trust at the Nottinghamshire and Derbyshire Multi -Agency Risk Assessment Conference (MARAC).

Quality assures all actions set by the MARAC chair for SFHFT are completed in the expected time frames.

Provides assurance to the Trust that written consent is gained by staff when undertaking a risk assessment (DASH) at all times and that confidentiality is maintained when sharing information within and outside of the organisation.

Provides support and advice to Sherwood Forest Hospital NHS Foundation Trust and to partner agencies in the analysis of cases and development of management plans/risk assessments.

Provides quality assurance to the Trust that the relevant information discussed at the MARAC is shared in accordance with information sharing policy with relevant people within the Trust on a case by case basis dependant on the level of risk.

Provides assurance to the organisation that referral pathways are in place to provide high quality patient care and appropriate signposting of individuals where there is an identified risk.

5.0 APPROVAL

Approval if through the Safeguarding Steering Group

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

6.1 Understanding why people may not disclose

Survivors of abuse may find it difficult to disclose in the absence of direct questioning because they are not sure what to say and how to start the conversation, fear of being judged/stigmatized or particularly for survivors not being believed. Concerned about what will happen next – will social care become involved? Will I be asked to leave? Feel ashamed/embarrassed, feel not worthy of support.

Cultural barriers, age, gender, sexuality or disability are all reasons that survivors do not disclose.

Asking about domestic violence and abuse can generate anxiety in professionals, fears of causing offence, opening Pandora's Box, not knowing what to do next and getting it wrong.

6.2 Set the scene

- Environments that display relevant information, demonstrates that Domestic Abuse is a healthcare issue that we care about.
- Be prepared to offer a worker of the same gender/ethnicity where available.
- Ensure it is safe to ask.
- Be clear about confidentiality.
- Never assume someone else is addressing the domestic abuse concerns.
- Never ask in front of a family member, friend or child.

6.3 Create the right environment

Create an opportunity to provide a quiet environment where confidentiality can be assured for the survivor to talk about their experience.

The survivor should NOT be asked about domestic abuse whilst accompanied by partners or other family members (including children), as they could be a perpetrator.

Where there are language or learning barriers use professional interpreters or staff trained in supporting clients with learning disabilities? Never use never family member, friends or children.

6.4 Develop an empowering relationship

- Survivors do not mind being asked, they always have the choice not to disclose.
- Survivors often want to be asked.
- Asking about abuse can generate confidence in the healthcare professional's ability to support/respond.
- You may be the only person to ask!
- If a person does not disclose but you suspect otherwise accept what is being said but offer other opportunities to talk.

6.5 Enquire 'Ask the question'

- Frame the question by explaining why you are asking.
- Assure them that their confidentiality will be respected in accordance with the law.
- Service users should also be made aware of the constraints of confidentiality, for example where there are safeguarding child/adult concerns.
- Using questions which people relate to easily, seem less frightening or judgmental.
- Avoid terms which people might not understand eg: domestic violence/sexual violence.

It is best practice to see the patient alone:

Staff should never raise the subject of domestic abuse if anybody else, including family and friends are present. The exception to this would be a professional interpreter or where a person with additional needs support e.g., learning disabilities.

It is important that the staff weigh up the risk of harm against potential benefits before attempting to see the patient on their own.

Assessment: What injuries have been sustained? Are there any children living in the home? Where are the children now? Did they witness the assault? Is the woman currently pregnant? Is the violence escalating? Is it safe for the survivor to go home? Are there any other vulnerable adults in the home? Sign date and time the information.

Be prepared that even if someone is experiencing abuse, they may deny it. Accept 'no' as the answer. Continue to be supportive and offer verbal advice along with a domestic abuse card if safe to do so.

Consider the need for an interpreter: Some patients may need someone else present as an interpreter or as an advocate if they are not able to speak fluent English. It is unacceptable and can be unsafe if it is a family member or friend.

Direct questions: should cover the different types of abuse that people might experience (physical, sexual, emotional, psychological and financial abuse)

If you think an injury is not consistent with the explanation, then it is ok to be honest. Explain to him/her that you are concerned.

Asking a person who access services directly about their experiences, if any, of domestic violence or abuse where there are suspicions or concerns, including the presence of indicators of abuse.

"That (injury) looks sore / painful has someone taken a look at that?"
"Did someone cause these injuries? Was it your partner/ex-partner?"
"You seem a bit down today, how are things at home?"

Ask direct questions in a supportive and sensitive manner. Do not be afraid to ask:

- Does your partner/ex-partner ever hurt you?
- Does your partner/ex-partner frighten you?
- Do you feel frightened or scared of your partner or someone at home?

- Does your partner/ex-partner ever make you do sexual things that you do not want to?
- Do you feel controlled or isolated from others by someone in your home?
- Does anyone at home put you down or insult you?
- Does your partner/ ex-partner ever threaten or intimidate you?

Listen to the person and validate

Listening and validating what is happening to the individual builds trust, establishes rapport and sends important messages to the survivor.

"You are not alone"
"You are not to blame for what is happening"
"You do not deserve to be treated in this way"
"What you have described is not uncommon"
"Thank you for sharing this with me it must have taken a lot of courage to talk about this with me"

6.6 Respond appropriately

- Act immediately on disclosures, assess and respond to risk.
- Ensure child safety is paramount.
- Adult safety is a priority.
- Consider the needs of the perpetrator.
- Documentation any suspicion of domestic violence and abuse within healthcare records can be used in relation to criminal justice proceedings and used in relation to MARAC (Multi Agency Risk Assessment Conferences)
- Be aware of local safeguarding children/adult procedures and use as appropriate.
- Share information appropriately.

6.7 Safety Procedure

When working with women/men and children it is vital that we prioritise their safety and do not collude with Domestic Abuse

Keep your boundaries: Never act as a go between or let anyone know the address of your patient.

Asking about the perpetrator's current whereabouts will help to determine immediate safety levels for both the survivor and the professional making the assessment.

When undertaking your assessment / observing / talking to the patient be mindful of other possible signs and symptoms of abuse other than the presenting problem. To help, see the potential indicators of abuse in **Appendix B(i) and Appendix B(ii).**

If the abuse is current, it is very important that staff do not advise the service user to do anything in the first instance, just offer support that she/he has disclosed and identify any safeguarding risks to children.

If the service user is not in immediate risk/danger, discuss the options that are available with him/her, Give service user's access to the telephone for the opportunity to contact the Police or other services themselves.

If there is an individual identified as a vulnerable adult – "who is or may be in need of community care service 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; staff must discuss their safety and contact the Trust Safeguarding Team and consider a referral to Adult Social Services to assess the safety and wellbeing of the individual. This must be clearly stated and recorded.

6.8 Offer immediate practical support

- Focus on safety – Assess the immediate safety of the survivor and any children.
- Is your partner here with you?
- Where are the children?
- Do you have any immediate concerns?
- Do you have a place of safety?
- Is it safe for them to return/remain at home?
- Complete a DASH risk assessment. The form can be found on the Trust intranet site under Safeguarding -Domestic Abuse folder https://sfhnet.nnotts.nhs.uk/admin/webpages/preview/default.aspx?RecID=4370
- Discuss and construct a basic safety plan where necessary.
- Be familiar with and give relevant information about local domestic violence services if safe to do so.
- Respect survivors' choice, it is not your responsibility to encourage them to leave, however you must observe relevant child/adult safeguarding procedures.

6.9 In situations where Forced Marriage is suspected or disclosed in addition to the above points ensure that you:

- Contact the Hospital IDVA or Safeguarding Team
- Refer them to the Forced Marriage Unit http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/information-for-victims
- Obtain full details to pass on to trained specialist
- Explain all the options to them and ensure that she/he can get information in a language and format that is suitable to their needs
- Consider the need for immediate protection and placement away from the family
- Establish a way of contacting them discreetly in the future.

see Force Marriage Policy for further information;
https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=30360

6.10 Working with male victims of Domestic Abuse

Men are less likely to report domestic abuse to police than women, and more likely to consider it a trivial matter. (NICE 2014) Male victims of domestic abuse are also more likely to seek help from an online resource or through friends than speak to a healthcare professional. (Douglas and Hines 2011)

Within Nottinghamshire men experiencing domestic violence and abuse are supported by Equation Service for Men. This service includes standard, medium and high risk cases expanded to include standard and medium risk cases.

Workers can now refer men living in Nottinghamshire experiencing domestic violence and abuse at any risk level to Equation. Men can also self-refer.

To make a referral for a standard or medium risk:

- Contact Equation on 0115 960 5556 to request a referral form or leave a message with your name, organisation and contact number.

- Complete a referral form and send to countyreferrals@equation.org.uk

To make a referral for a **high risk follow the MARAC procedure**

6.11 Domestic violence/abuse and safeguarding children

Children may suffer both directly and indirectly in households where there is domestic violence and abuse. In 2005 the Adoption and Children Act 2002 was amended to include 'harm caused by the witnessing of abuse or ill treatment of another'.

More recently in 2021 the Domestic Abuse Act saw children being recognised as victims whether they were present during violent incidents or not.

Therefore a referral should be made to Local Authority Children and Young People's Services if a child lives in a household where domestic violence is believed to be a factor which may lead to them being in need of support or protection.

Similarly, children and young people are at risk of experiencing domestic abuse directly within their own relationships, with 16-24-year-old women being at highest risk of domestic violence, sexual assault and rape, forced marriage and FGM.

In these instances, there are specialist DASH forms that can be used to assess risk, these can be accessed via the safeguarding intranet or by contacting the safeguarding team on ext. 3357

6.12 Older People

Older people (60 plus) who experience domestic abuse historically form part of a 'hidden group'. Professionals need to be aware that older survivors of domestic abuse are less likely to engage with support services. Older people are more socially isolated and in position where they may be caring for the perpetrator or be in fact cared for by the perpetrator. Due to heath issues older victims may not be able to physically access support, or health issues of the perpetrator (e.g., dementia) may mean there is additional pressure to remain in the relationship.

Older victims who disclose abuse may have been in this situation for decades. Most survivors are women but there is evidence which suggests that there is a much higher proportion of older men experiencing abuse (16%) compared to under 60 (4%) (Safer Lives 2016).

Professionals need to ensure that if domestic abuse is disclosed then support and advice is freely offered. Staff also needs to take the appropriate steps to act in the person's best interest if the victim or perpetrator lacks mental capacity.

6.13 Older People with Dementia

Having dementia places older people at an increased risk of abuse within their home environment and particularly from a caregiver. Research shows that psychological and verbal abuse are the most common; people with dementia are also vulnerable to neglect, physical, sexual and financial abuse.

The cognitive and communication impairments experienced by a person with dementia can mean it is more difficult to detect abuse. Signs and symptoms that abuse is occurring may be confused with symptoms of dementia and so careful assessment with the person, the caregiver and of the environment is important. Signs that a person with dementia could be being abused may include physical evidence such as unexplained injuries and bruising, pain, changes in appetite and sleep and behavioural/ psychological distress such as difficulties accepting care, withdrawal, avoidance of eye contact, vocal expressions of distress and hyper vigilance. Evidence shows that caregivers will often admit to abuse, so it is important to sensitively ask both the carer and, as appropriate, the person with dementia, about possible abusive behaviours.

Risk factors for domestic abuse of people with dementia may be related to the characteristics of both the person with dementia and their carer, the quality of their relationship and the caring environment. In the person with dementia, increased cognitive impairment, behaviours that challenge and the presence of mental illness or psychological difficulties can all indicate an increased risk of abuse. If the person with dementia is, or has been (for example pre-morbidly) abusive towards the caregiver, this is also a risk factor for abuse and can lead to an escalating cycle of aggression and abuse between the person with dementia and their carer.

In the caregiver, risk factors include experience of mental health problems, experiencing carer burden and a lack of effective coping strategies in caring for the person with dementia.

In the environment, issues of levels of support and time spent caring through the day are important. A poor relationship between the cared for and caregiver, and a history of this, is a risk factor for abuse. It is important to remember that the carer may also be at risk of abuse (e.g. verbal, physical or sexual) from the person with dementia, especially where there is a history of a controlling or abusive relationship.

Financial abuse of a person with dementia can be difficult to detect, partly due to their potentially not being able to detect or report it themselves, and partly due to a possible sense of entitlement on the part of family who may be mismanaging the person's affairs.

Assessing for the possibility of sexual abuse, as opposed to sexual activity, can also be complex. It is important to take a person-centred approach that takes into account the relationship context of the sexual activity, the person's pre-morbid values and preferences, their capacity to consent and their usual ways of showing assent and dissent in their close relationships.

It is important to assess early for potential abuse and risk factors, or behaviours that do not meet a definition of abuse but that are signs that are carer is not coping. In many cases, abuse of a person with dementia may not be intentional. Factors that have been found to help in cases of caregiver/ cared-for abuse and 'pre-abuse' include treating cognitive and non-cognitive symptoms in the person with dementia, providing information/ education to the carer about dementia, teaching coping strategies and offering home care and/or respite care

6.14 Adolescent to Parent Violence

Taken from Institute for Research and Innovation in Social Services
https://www.iriss.org.uk/resources/esss-outlines/adolescent-parent-violence

Definition

Adolescent to parent violence and abuse (APVA) was first differentiated from other forms of familial violence as 'battered parent syndrome' (Harbin and Madden, 1979), referring to:

- "Any harmful act by a child, whether physical, psychological or financial, which is intended to gain power and control over a parent or carer"

It's a term that has evolved since then, and while there remains a lack of consensus on definitions and terminology, it can be broadly seen as a pattern of habitual, coercive behaviours that reverse the parent / child power dynamic (Wilcox, 2012).

The term AVPA itself presents problems. It is most likely 'mother' – as opposed to 'parent' – who is the recipient of APVA. Abuse also defines the child as an 'abuser' which is arguably not an appropriate or helpful way of positioning someone under the age of 18 (Holt, 2011).

There is currently no legal definition of APVA. Depending on the age of the child, it may fall under the government's official definition of domestic violence and abuse (Home Office, 2015):

"...any incident or pattern of incidents of controlling, coercive or 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. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse."

The UK Government's draft Domestic Abuse Bill (HM Government, 2019) makes reference to APVA, but some feel it does not adequately capture its complexities, the experiences of families, or make a clear commitment to statutory support for those affected (Adoption UK, 2019).

Prevalence

Despite recognition from practitioners, APVA has been, and continues to be, a relatively unexplored area. It is a particularly hidden form of domestic violence, and like other forms of domestic abuse is under-reported (Holt, 2011).

As policy has only recently begun to address the problem, incidents of APVA are not usually officially recorded or flagged, so prevalence is hard to gauge (Home Office, 2015). Without an understanding of the scale of the issues it is difficult to deliver appropriate policy and funding.

In 2009, Parentline Plus reported receiving an average of 95 calls to the helpline each month from parents concerned about their child's verbal and / or physical aggression towards them: 91 percent of the callers were female, with the majority of children aged between 13 and 15 years (Holt, 2012b).

6.15 Disability

Disabled people experience disproportionately higher rates of domestic abuse than the general population. Research also shows that people with a disability experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people. They may also experience domestic abuse in wider contexts and by greater numbers of significant others, including intimate partners, family members, personal care assistants and health care professionals. This is true for all types of abuse - physical, financial, emotional or sexual.

Disabled people are:

- 3 times more likely to experience gender-based violence (sexual violence, rape, neglect and exploitation) compared to non-disabled population.
- Disabled women are 2-4 times more likely to experience serious sexual violence than nondisabled women or disabled men internationally. (Hughes, 2012)
- 2.5 times more likely to experience lifetime prevalence of domestic violence than nondisabled women.

Specific risk factors

People with a disability are often in particularly vulnerable circumstances that may reduce their ability to defend themselves, or to recognise, report and escape abuse. Impairment can create social isolation, which, along with the need for assistance with health and care, raises the risk of domestic abuse for disabled people. Often reliance on care increases the situational vulnerability to abuse and can exacerbate difficulties in leaving an abusive situation. It is also important to remember that for some people this is support around intimate personal care, which can make some forms of abuse more likely to occur and more difficult to identify. For some people they may struggle to identify that a relationship that should be loving and caring is in fact abusive. Cognitive / communication difficulties may also be a barrier to the person being able to communicate what is happening to them. Additionally, the person being abused may receive a financial or emotional reward which means they may find it difficult to disclose what is happening to them.

Carers may also be managing difficult behaviour which makes it more difficult to identify when use of restrictions or control is inappropriate and should be seen as a safeguard. However, it is also important to remember that managing challenging / aggressive behaviour is in itself a risk factor for domestic abuse occurring. A detailed assessment of the situation is required to ensure that risks are identified and appropriately manged. The safeguarding process should be a central part of manging this.

It is also important to consider that the carer may also be the victim of domestic abuse from the person that they care for and this needs to be considered alongside the consideration of risk to the person with a disability.

There are a number of easy read leaflets which may be useful when assessing or discussing these issues with a person with a disability e.g. a braille copy of information re the DA helpline and easy read cards to support people with a learning disability to contact the DA helpline

6.16 LGBTQ+

There are a number of specific issues that are unique to LGBTQ+ survivors who experience domestic violence. These include:

- Threat of disclosure of sexual orientation and gender identity to family, friends, or work colleagues. It is worth remembering some trans people will be in hetero passing relationships and others in openly gay relationships
- Increased isolation because of factors like lack of family support or safety nets.
- Undermining someone's sense of gender or sexual identity.
- Limiting or controlling access to spaces and networks relevant to coming out and coming to terms with gender and sexual identity.
- The abused may believe they 'deserve' the abuse because of internalised negative beliefs about themselves.
- The abused may believe that no help is available due to experienced or perceived homo/bi/ transphobia of support services and criminal justice system.
- Professionals may be less aware of the potential for domestic abuse in LGBTQ+ relationships.

Specific reference to LGB partner abuse:

- Using society's heterosexist myths about aggression and violence abusive partners may manipulate and convince their partner that no one will believe the abuse is real.
- Abusive partner may manipulate their partners into believing that abuse is a 'normal' part of same-sex relationships.
- Abusive partners can give the idea that the violence is mutual or that the abused partner consents to the abuse.
- Abusive partner may threaten to call the police and claim they are the abused person.
- The abusive partner may pressure their partner to minimalise abuse to protect the image of the LGB community.
- If the abused partner is living in the UK on a spousal visa, abuser might take advantage of their lack of awareness about immigration law, and threaten to deport them back to their country of origin, which might be unsafe due to e.g.: anti-gay legislation.

<u>Transgender</u>

The term 'transgender' is used to describe anyone who identifies differently to the gender they were assigned at birth. There is no one way to 'be transgender' and it is a term that is personal to the person using it. Some people identify within the binary of man or woman,

whilst others identify outside of these as non-binary or gender fluid. Transgender people may seek gender affirming medical interventions and use a range of pronouns, including him/his, she/her or they/their

Specific reference to transgender persons:

- Withholding medication or preventing treatment needed to express victim's gender identity (e.g. hormones, surgery).
- The abuser might refuse to use correct pronouns and prevent the abused from telling other people about their trans background or identity.
- The abuser might use pejorative names and ridiculing persons' body image (body shaming).
- The abuser might convince or manipulate their partner that nobody would believe them because they're transgender.
- The abuser might deny a person's access to medical treatment or hormones or coercing them into not pursuing medical treatment.

There is access to LGBTQ+ specific Domestic Violence cards and specific evidence gathering tools that can be used where the DASH risk assessment result is low risk. This checklist identifies behaviours LGBT+ victims experience and is used to inform professional judgement. These resources are available via the safeguarding intranet or by contacting the safeguarding team on ext. 3357

6.12 Female Genital Mutilation (FGM)

Female Genital Mutilation comprises all procedures involving partial or total removal of, or injury to, the female genitalia for non-medical reasons (HMG, 2014).

It is an offence to subject someone to FGM in this country or to remove them to another country for the purpose of FGM.

Female Genital Mutilation causes significant and lasting physical and emotional harm to women and girls. FGM is not a religious requirement. It is a cultural practice. Safeguarding women and girls is not racist, discriminatory, or disrespectful, but does need sensitivity and awareness in how actions are taken forward.

On October 1st, 2015, legal duty to report FGM to the police came into force. Professionals must phone the police non-emergency crime number, 101, if a patient under the age of 18:

a) Tells you she has had female genital mutilation
b) Has signs which appear to show she has had female genital mutilation

FGM procedures and risk assessment tools are available within the trust FGM policy:

https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=47964

6:11 FOR LOCAL DOMESTIC ABUSE ORGANISATIONS AND CONTACT NUMBERS, See Appendix D

6:12 Domestic Violence & Abuse (DVA) Response Pathway

- REFER TO APPENDIX C

6:13 Staff need to contact the Domestic Abuse Nurse or Safeguarding Team on Ext 3357 after gaining and documenting all the relevant information if possible

The assessor must establish a rapport with the victim by fully explaining their role and responsibility within the organisation. It is important to understand that victims may be more willing to make disclosures to professionals not associated with the law (police or courts).

6:14 Documentation and record keeping:

This is important as medical records can be used in the event of a perpetrator being charged with a domestic abuse related offence. All documentation should be clear and accurate. Records can be concrete evidence of abuse and may play a crucial part in any legal case. Therefore:

- Record all injuries seen - you can use a body map
- Document name of the abuser.
- Document name of the person accompanying them to the hospital
- Record the outcome and any action taken.
- Ask and document whom the victim leaves the hospital with and document the address they are being discharged too.
- Document any weapon/s that have been used in the assault or any previous assaults i.e. knives. TV remote, cups, chairs
- Document any children living in the home or any other children that are siblings or stepchildren, foster children currently in the care to of victim or perpetrator.
- Record if there is any ongoing pregnancy
- Document if the abuse is **happening more** often and is **getting worse.**
- Document if there are any drugs, alcohol, or mental health issues.
- Document any vulnerable adult living or visiting the home
- Document any stalking/harassment e.g. texts, being followed

The recording of domestic abuse should be:

F Factual
A Accurate
C Confidential
T Timely

Factual: Information should not be an opinion and should be relevant to the incident or injury.

Accurate: Injuries should be documented in as much detail as possible. Body maps can be used.

Confidential: Confidentiality should be discussed with the patient and their consent should be obtained if information needs to be shared with other agencies or other health professionals.

Timely: Information should be recorded at the earliest opportunity in order that the information is recorded accurately.

Information to the patient's GP

Any patient who discloses domestic abuse whilst in the **Emergency department (ED) or the Urgent care Centre (UCC) ONLY**:

The patient **MUST** be asked by the clinical assessor if they consent to their information about the attendance being disclosed to their GP. However, in some circumstances information will need to be disclosed without consent to the GP due to concerns raised from assessment or as described in the flow diagram (see **Appendix E**).

6:15 Survivor's level of fear

While the survivor's own level of fear is a good indicator of their level of risk, there are times when the survivor may not be able to accurately assess their level of risk. For example, this may occur when the victim has a mental health issue, intoxicated or when the victim has lived with violence for many years and has become desensitised to it. Therefore, you must use all the information obtained from the full assessment to determine how much risk there is. The following questions will allow you to explore their view about the level of risk.

- How scared do you feel given this last incident?
- Do you think the violence will continue?
- Is the violence escalating and becoming more severe?
- Are you safe to return home?

6:16 Advice for those experiencing Stalking

- The Trust seeks to support any staff member who may experience stalking to minimise the risk, promote safety whilst at work and to offer support with the impact this behaviour may have on their ability to perform effectively at work or during legal or other proceedings.

- The definition of stalking is: "two or more incidents (causing distress, fear or alarm) of obscene or threatening unwanted letters or phone calls, waiting or loitering around home or workplace, following or watching, or interfering with or damaging personal property by any person, including a partner or family member."

Presentation of a staff member being stalked could include:

- Increased absences, arriving late for work, or poor work performance.
- Any changes in an employee's productivity may be caused by stalking and this should be considered when managing these issues.
- Identifying that a staff member is experiencing difficulties at an early stage will lead to appropriate help being offered, which will make it easier for the victim to deal with the situation — and improve the safety of both the victim and the rest of the staff.
- Needing time off work to attend repeated legal appointments etc.

The Trusts HIDVA has access to material to support those who are experiencing stalking

Please see **Appendix F** for advice and support in responding to stalking and harassment

6:17 Information sharing

All professionals must be familiar with, and follow their own Professional Code of Conduct and the Trust Confidentiality Policy.

Explain that confidential help is available from local services.

If the patient does not wish to engage with a DASH assessment:

- The patient's wishes regarding the options available to them and regarding their decision and consent to share information or not are to be respected.
- Written and verbal information is to be given to the patient (if safe to do so) by the professional.
- However in some extreme circumstances the Domestic Abuse Specialist Nurse may have a duty to share information **without** the consent of the patient; examples include where there is **extreme** violence displayed or there are **significant concerns** for the safety of the victim, **concerns for the wellbeing of a child/ren** or **other** vulnerable persons.

However a DASH can be completed from the assessment and a referral made to MARAC based on the clinician's professional judgement.

If the patient is willing to engage then:

Written consent **must be** sought on the DASH form and obtained before any disclosure to other parties **unless**, there are children involved. In this case a referral should be made to Children's Social Care following safeguarding procedure (see the Safeguarding Children Intranet Site for guidance), and the Safeguarding Children Team informed.

The welfare of children is paramount and outweighs the victim's need for complete confidentiality.

This should always be assessed using practice guidance *Interagency Practice Guidance in Relation to Children and Domestic Violence* (The link is available on the SFHFT Child Safeguarding Children and Young People intranet site). Information should also be shared with the relevant community health professionals involved with the children.

Discussions about the referral should never be held in the presence of the abusing parent/carer nor should they be given any information about the referral as this may put the patient and/or children at increased risk of harm.

6:18 Legal grounds for consideration of information sharing without consent

- Prevention and detection of crime
- Prevention / detection of crime and/or apprehension or prosecution of offenders (DPA, schedule 29)
- To protect victim or others from serious harm or matter of life or death (DPA schedule 2 & 3)
- For the administration of justice (usually bringing perpetrators to justice) (DPA, schedule 2 & 3)
- For the exercise of functions conferred on any person by or under any enactment (Police/ Social Services) (DPA, Schedule 2 & 3)

- In accordance with a court order
- Overriding public interest (common law)
- Child protection – disclosure to Social Services or Police for the exercise of functions under the Children Act where the public interest in safeguarding the child's welfare overrides the need to keep the information confidential (DPA, schedule 2 & 3)
- Right to life (Human Rights Act, art. 2 & 3)
- Right to be free from torture, of inhuman or degrading treatment (Human Rights Act, Art. 2 & 3)

6:19 Confidentiality and consent

The assessment should take place in a room in which confidentiality can be assured and where the patient cannot be overheard or seen from the outside room.

Be clear about confidentiality, but be clear about its limits and explain these to the patient i.e. **referral to Social Care**

6:20 Actions

Reassure the service user that she/he had done the right thing by reporting the issue, and that there is help available. Discuss with them whether she/he has any safety/strategy plans in place already and how they will be helpful in the first instance.

6:21 Public information

It is important that all service users are able to access information about what help is available. This can be done by ensuring that all wards/departments display;

- **Information cards**: These are available in many different languages and should be easily accessible.
- **Posters:** These should be available in all areas of the department/ward/clinics and in the public toilet areas.
- There should be **24 hour help line numbers** available for the staff to give out if needed.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

7.1 Managers are required to ensure that this policy is adhered to.
The effectiveness of this policy will be monitored through the Trust Safeguarding Steering Group, through the reporting of Domestic Homicide Review findings, Serious Case Review Findings, Safeguarding Adult Review findings, Serious Untoward Incident forms, Incident Reporting Forms, Safeguarding Team quarterly reports and Data Capture.

7.2 An annual safeguarding report including Domestic abuse activity will be presented to the Trust Safeguarding Steering Group and Patient Safety Quality Board for Safeguarding and relevant Governance assurance processes.

7.3 The Trust will conduct internal audits to monitor compliance to national and local directives as part of its approach to domestic abuse, which will be reported to the Trust Safeguarding Steering Group.

7.4 The Trust will participate in internal and external audits as identified which will include exception reporting to the Trust Board.

7.5 Domestic Abuse Awareness is part of Sherwood Forest Hospital NHS Foundation Trust Safeguarding Think Family training Learning and is reported to The Trust Safeguarding Steering group.

7.6 The Safeguarding Team will monitor progress against improvement plans arising from recommendation/incidents from serious case reviews, adult reviews and domestic homicide reviews and report to the Trust Safeguarding Steering Group.

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Completion of DASH assessment and referral to MARAC	Named Nurse Safeguarding Adults	Audit	yearly	Safeguarding Steering Group

8.0. TRAINING AND IMPLEMENTATION

All Sherwood Forest NHS Foundation Trust employees will attend Domestic Abuse training at a level identified appropriate to their role and responsibilities (NICE 2015, Nice Quality Standard 2016)

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix G
- This document is not subject to an Environmental Impact Assessment.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Browne J (MP) and The RT Honorable Green (MP) (2013) Home Office Crime and policing London, Home Office
- CAADA (2012) A Place of Safety: Insights into Domestic Abuse 1. Bristol
- CAADA (2010) Saving lives, saving money: MARAC's and high domestic abuse: Bristol
- Care and support statutory guidance (2016) Department of Health
- Crime and Disorder Act 1998 section 5-7.
- Department of Health (2005) Responding to Domestic Abuse: a handbook for professionals London DH
- Department of Health (2006) Tackling Health and Mental Health Effects of Domestic and Sexual Violence and Abuse
- Department of Health (2010) The Department of Health Action Plan
- Domestic Violence and Abuse Nottinghamshire Joint Strategic Needs Assessment (2014)
- The Domestic Abuse Act (2021)
- Department of Health (2015) Safeguarding women and girls at risk of FGM.
- Department of Health (2016) Multiagency statutory guidance on female genital mutilation
- Forced Marriage and Learning Disabilities; Practice Guidelines (2012)
- Forced Marriage: Multi agency practice guidelines (2013)
- HMIC (2014) Nottinghamshire Police's approach to tackling domestic abuse. Inspecting Policing in the Public interest
- Hunt R, Fish J (2008) Prescription for change: lesbian and bisexual women's health check. London: Stonewall
- Improving Safety, Reducing Harm. Children, young people and domestic violence. A practical toolkit for front-line practitioners Department of Health (2009)
- NHS Operating Framework 2011-2012 (Department of Health, 2010)
- NICE (2014) Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE London
- Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08
- Protection of Freedoms Act 2012

- Radford et al (2011) Child Abuse and neglect in the UK today, London, NSPCC
- Ratti A (2012) New domestic abuse guidelines issued by government
- Safelives (2014) Guidance for MARAC: Addressing the abusive behaviour of alleged perpetrators
- Serious Crime Act 2015
- Smith, K Osbourne S, Lau I, & Britton A, (2012) Homicides, Firearm offences and intimate partner violence 2010/2011: Supplementary volume 2 Crime in England and Wales, London
- Statutory Guidance for the conduct of Domestic Homicide Reviews (Home Office, 2011)
- Striking the Balance, Practical guidance on the application of Caldicott Guardian principles to domestic violence and MARACS (multi agency risk assessment conferences) (DoH, 2008)
- The Care Act (2014) Department of Health
- Walker, A Flatley, J. Kershaw, C. AND Moon D. (2009) 'Crime in England and Wales 2008/09: Volume 1-Findings from the British Crime Survey and police recorded Crime'. London: Home Office.
- Working Together to Safeguard Children:(2018)

Related SFHFT Documents:

- Policy for the Management of Violence and Aggression at Sherwood Forest Hospitals NHS Foundation Trust
- Safeguarding Children Policy.
- Safeguarding Adults Policy
- Confidentiality Policy
- Staff Domestic Abuse Policy

11.0 KEYWORDS

Violence, Victim, Survivor, Perpetrator, DASH, Risk Assessment, Safeguarding, MARAC

12.0 APPENDICES

Appendix A	Types of Domestic Abuse
Appendix B (i)	Potential Indicators of Domestic Abuse in Adults
Appendix B (ii)	Potential impact of domestic abuse on Children
Appendix C	Domestic Violence & Abuse (DVA) Response Pathway
Appendix D	Local domestic abuse organisations and contact numbers
Appendix E	Procedure for a Discharge Letter to a GP
Appendix F	Stalking
Appendix G	Equality Impact Assessment Form

Appendix A: Types of Domestic Abuse

Physical abuse can include:
Shaking, smacking, punching, kicking, pinching, hair pulling, presence of finger or bite marks, starving, withholding medication, withholding access to wheelchairs or other equipment, tying up, stabbing, suffocation, strangling, throwing things, using objects as weapons, causing miscarriage, being thrown, female genital mutilation, 'honour violence'.

Physical effects are often inflicted on areas of the body that are covered and hidden eg breasts and abdomen

Sexual abuse can include:
Forced sex, forced prostitution, ignoring religious prohibitions about sex, not being allowed to use contraception, deliberately passing on sexual infections, sexual humiliation and degradation, being kept pregnant, being forced to have an abortion, preventing breastfeeding, being forced or coerced into taking part in sexual activity that someone is not comfortable with, including watching or making pornography, female genital mutilation (FGM), sexting.

Psychological and Emotional abuse can include:
Humiliation and degradation; minimising and denying the abuse; blaming for the abuse- on cultural/ethical beliefs; stress; alcohol or drug use; insulting, belittling a partner's cultural or ethical beliefs; being jealous and possessive, justifying abuse through children; isolating a partner – not allowing them to leave the house, go to work, see friends or family; stalking- watching, following and making constant phone calls to check on a partner's whereabouts; threats to 'out' a Lesbian, Gay, Bisexual or Transgender partner; threats to report a partner to immigration; threats to harm or murder a partner, children and pets; threats to commit suicide.

Financial abuse can include:
Denying access to or information about money; undermining efforts to find work or study; scrutinising how money is spent; stealing money from a partner or children; running up debts under a partner's name, not paying bills; making a partner beg for money.

Stalking/Harassment:
The term harassment is used to cover the 'causing alarm or distress' offences under section 2 of the Protection from Harassment Act 1997 'putting people in fear of violence' offences under section 4 of the same Act. Although harassment is not specifically defined it can include repeated attempts to impose unwanted communications and contacts upon a victim in a manner that could be expected to cause distress or fear in any reasonable person.

Whilst there is no strict legal definition of 'stalking', circumstances associated with stalking include: physical following; contacting, or attempting to contact a person by any means (this may be through friends, work colleagues, family or technology); or, other intrusions into the victim's privacy such as loitering in a particular place or watching or spying on a person.
The effect of such behaviour is to curtail a victim's freedom, when carried out repeatedly it may then cause significant alarm, harassment or distress to the victim.

Technological Abuse
The use of technology to perpetrate domestic abuse, referred to as tech abuse, has become increasingly common. Domestic abuse charity Refuge reported that in 2019, 72% of women accessing its services said that they had been subjected to technology-facilitated abuse. Common devices such as smartphones and tablets can be misused to stalk, harass, impersonate and threaten victims. Some groups have raised concerns that the growing use of internet-connected home devices (such as smart speakers) may provide perpetrators with a wider and more sophisticated range of tools to harm victims. How is technology being used to perpetrate domestic abuse, how can this be prevented and what role can technology play in supporting victims?

Appendix B: (i) Potential Indicators of Domestic Abuse in Adults

A survivor may not always present with obvious physical injury. Abuse can include threats, coercion and insults, as well as social and economic control. The survivor may not recognise this is abuse. People are often reluctant to disclose abuse because of fear or shame, or because they think that they won't be believed.

The following are potential indicators of domestic abuse which may trigger the need for selective enquiry.

This is not an exhaustive list. **The risk of experiencing domestic violence or abuse is increased if someone:** is female, is aged 16–24 (women), has a long-term illness or disability, has a mental health problem, is a woman who is separated – there is an elevated risk of abuse, planning to leave or separation

The risk is also increased if a woman is pregnant or has recently given birth.

- Frequent appointments for vague symptoms
- Frequent missed appointments
- Injuries inconsistent with explanation of cause
- Patient tries to hide injuries or minimise their extent
- Partner is aggressive or dominant, talks for the patient or refuses to leave the room when asked
- Partner always accompanies patient for no apparent reason
- Patient is submissive and/or reluctant to speak in front of partner; they appear frightened, overly anxious or depressed
- Patient presents with unexplained bruises, whiplash injuries consistent with shaking, areas of erythema consistent with slap injuries, lacerations, burns or multiple injuries at different stages of healing
- Injuries to the breast or abdomen
- Injuries to face, head or neck- common injuries include perforated eardrums, detached retinas
- Recurring sexually transmitted infections or urinary tract infections
- Evidence of sexual abuse
- Hair loss- consistent with hair pulling
- Presentation with alcohol and/or substance abuse, depression, anxiety, self-harm, eating disorders or psychosomatic symptoms
- Obsessive compulsive disorder
- History of behaviour problems or unexplained injuries or abuse affecting children
- Suicide attempts
- History of repeat miscarriages, terminations, still births or pre-term labour
- Poor contraceptive use
- Poor or non-attendance at antenatal clinics
- Non-compliance with treatment
- Early self-discharge from hospital
- Review of medical record reveals that patient has presented with repeated 'accidental' injuries

Appendix B: (ii) Potential impact of Domestic Abuse on Children

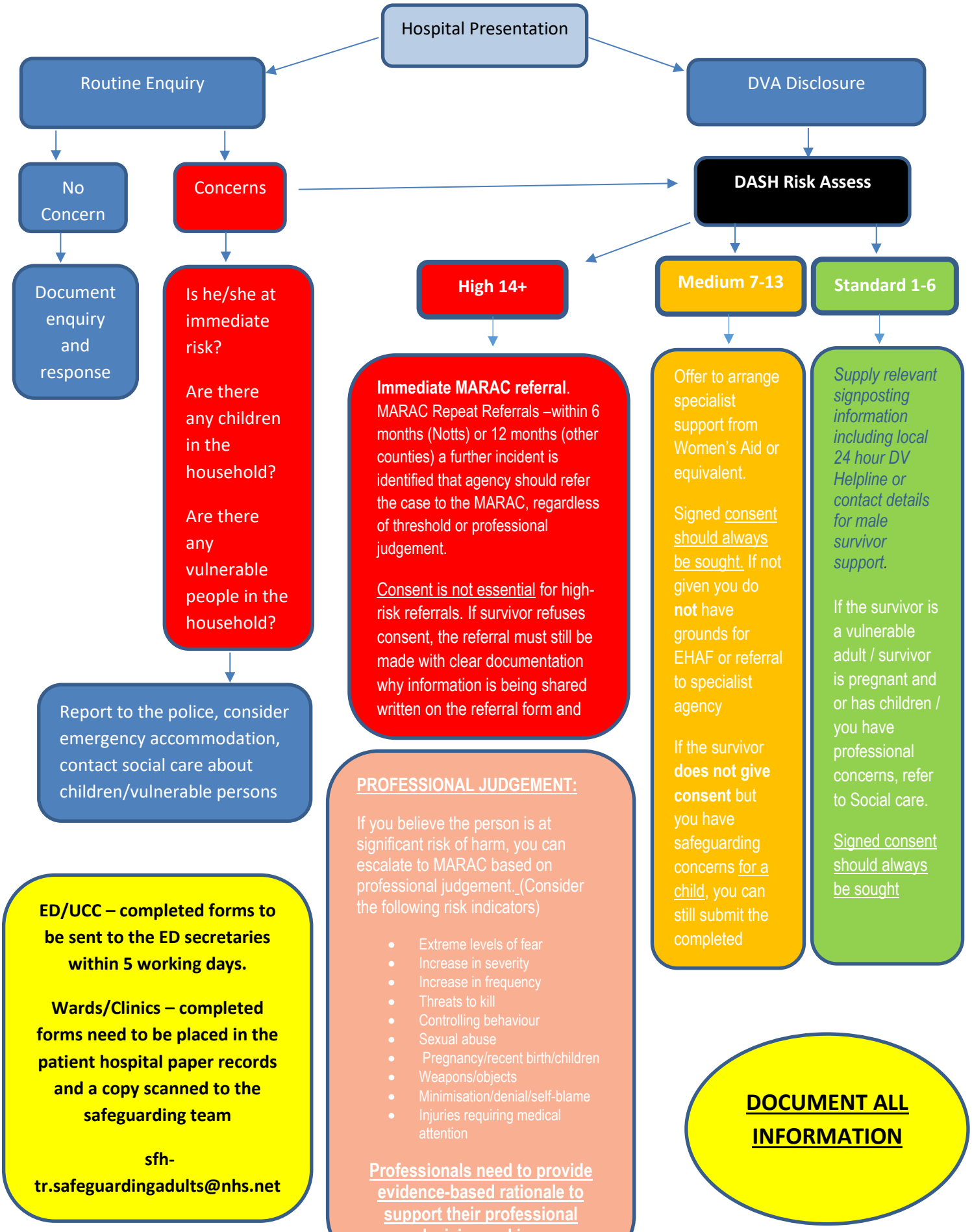
Whilst a child will respond differently to the abuse they have witnessed or experienced depending on their age, their personal resilience and support mechanisms, there is evidence that children suffer long term damage through living in a household where domestic violence and abuse is taking place even though they themselves may not be directly harmed. Their emotional, physical and psychological development may be impaired.

Impact on the child or young person's health can include:

- Physical injury e.g., broken bones and bruises
- Death
- Neurological complications
- Premature birth, low birth weight and/or brain damage
- Failure to thrive or weight loss
- Stress related illness, asthma, bronchitis or skin conditions
- Speech and language delays
- Tiredness and sleep disturbance
- General poor health
- Enuresis or soiling
- Substance and alcohol misuse
- Mental health issues such as depression and anxiety
- Eating disorders
- Damage following self-harm
- Teenage pregnancy
- Low self-esteem and self confidence
- Behavioural and emotional disturbance
- Introversion or withdrawal
- Thoughts of suicide or running away
- Post traumatic stress disorder
- Anger, aggressive behaviour and delinquency
- Assumes a parental role
- Hyperactivity
- Sexual problems or sexual precocity
- Suicide attempts
- Difficulty in making and sustaining friendships
- Truancy and other difficulties at school

(Ref Improving Safety, Reducing Harm: Children, Young People and Domestic violence. A Practical Toolkit for Front- line Practitioners DOH Sept 2009)

Appendix C - Domestic Violence & Abuse (DVA) Response Pathway

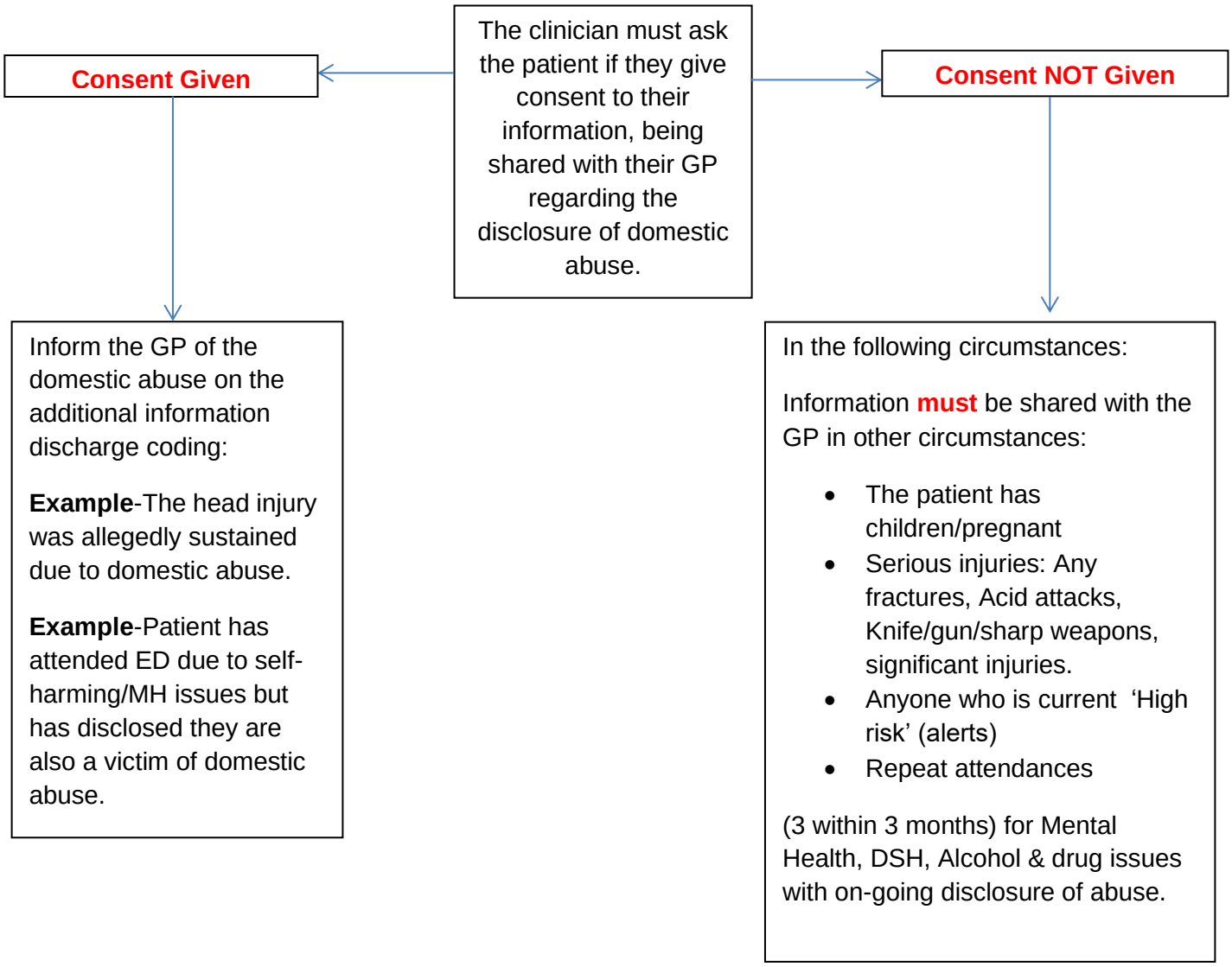


Appendix D - Local Domestic Abuse Organisations and Contact Numbers

For Female survivors	
Helpline Numbers	
Nottinghamshire Domestic Violence 24 hour free phone helpline number	Tel: 0808 8000 340 Text phone: 0808 8000 341 with Language Line
National Domestic Violence Helpline 24 hour free phone	Tel: 0808 2000 247
Topaz Centre (Sexual Abuse and Violence)	Tel: 0800 0859993
Nottingham Sexual Violence Support Services (NSVSS)	Tel: 0115 941 0440
Refs 4 Pets(If animals may be at risk and are a barrier to leaving).	Tel: 07971 337 264
North Nottinghamshire Providers	
Nottinghamshire Women's Aid (NWA)	Tel: 01909 533 610
Newark Women's Aid	Tel: 01636 679 687
North Nottinghamshire Independent Domestic Abuse Service (NNIDAS)	Tel: 01623 683250
South of the County and City providers	
Juno Women's Aid	**0808 8000340**
Broxtowe Women's Project	Tel: 01773 718555
Midlands Women's Aid	Tel: 0300 3020035/0115 9247647
	Tel: 0115 925 7647
For Male survivors	
Men's Advice Line Tel:0808 01 0327 www.mensadviceline.org.uk	Help and support for heterosexual, gay, bi and transgender male survivors of domestic violence and abuse
Victim Support Tel: 0300 303 1947	Supports standard and medium risk male survivors of domestic violence and abuse
GALOP 0800 9995428	Specialist support for lesbian, gay, bisexual and transgender (LGBT) people experiencing domestic violence
For male/female perpetrators	
Respect Phoneline Tel:08088024040 www.respectphoneline.org.uk Email: info@respectphoneline.org.uk	Help and Information for male and female perpetrators
Forced Marriage Forced Marriage Unit Karma Nirvarna Helpline	Tel: 020070080151 Tel: 08005999247
FGM NSPCC 24hr FGM Helpline	Tel: 08000283550

Nottinghamshire Public Protection Unit (PPU)	
Mansfield/Ashfield	01623 483947
Bassetlaw and Newark	07909 934447 01909 500999 extn 7530 / 7531
City	0115 967 6999
Nottingham South	0115 944 4014
Other Support Agencies : • Amber House Refuge: 0115 941 4279 • Shine (Housing related support)-0115 822 0833 • Umuada Refuge-0115 933 8202 • Victim Support (For Men and Women): 0845 450 3899 (8-8) • Childline: 0800 1111 or access to refuge contact: 0808 8000 340 • Shelter: 0808 800 4444 • Framework: 0115 841 7711	
Equation – support for male victims	0800 995 6999 (mon-fri, 9:30-4:30) helpline@equation.org.uk
Derbyshire DA helpline	08000 198 668

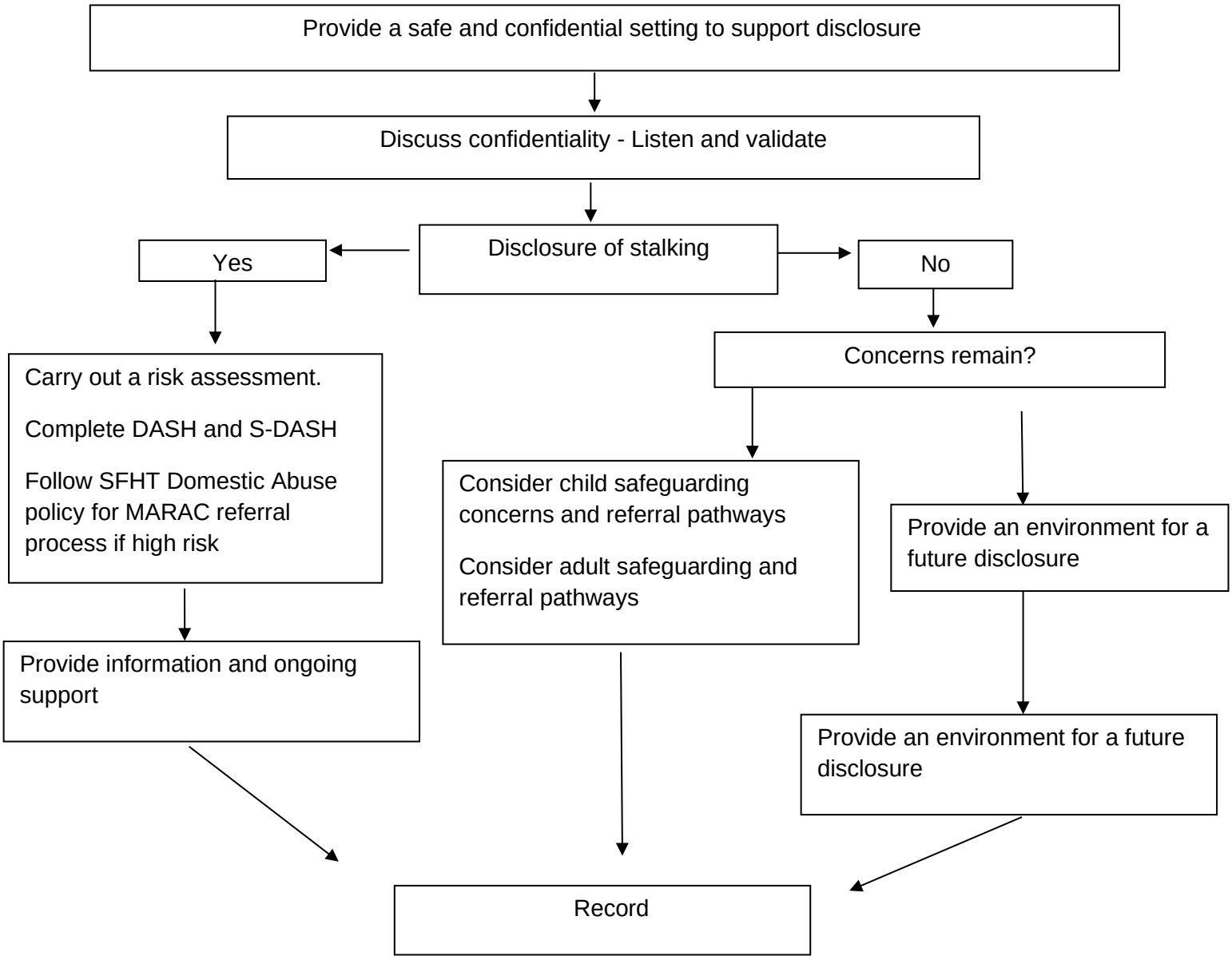
Appendix E - PROCEDURE FOR A DISCHARGE LETTER TO A GP FOR PEOPLE WHO HAVE ATTENDED THE EMERGENCY DEPARTMENT/ UTC AND HAVE DISCLOSED DOMESTIC ABUSE



Any intelligence re firearms needs sending to the police via email to hqcj.firearms@nottinghamshire.pnn.police.uk
Your professional judgement is to be used at all times and followed up with relevant documentation.
If you are unsure discuss with the Safeguarding Team (Ext 3357) or the ED Consultant.

Appendix F

Stalking



SOURCES OF HELP

National Stalking Helpline 0808 802 0300 www.stalkinghelpline.org

Paladin, National Stalking Advocacy Service 0207 840 8960 www.paladinservice.co.uk

Digital Stalking http://www.digital-stalking.com/

DASH and S-DASH risk assessment forms are available on the Trust internet

Use the Sherwood Forest Hospital NHS Foundation Trust Domestic Abuse Policy (available on the intranet)

Seek further advice / support from the trust safeguarding team on Ext. 3357

APPENDIX G – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Domestic Abuse Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 20/06/2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	This policy provides equitable care for all patients irrespective of race or ethnicity	This policy replaces the previous Domestic Abuse policy	None
Gender	This policy provides equitable care for all patients irrespective of gender	This policy replaces the previous Domestic Abuse policy	None
Age	This policy provides equitable care for all patients irrespective of age and is relevant to all patients over the age of 16 years	This policy replaces the previous Domestic Abuse policy	None
Religion	This policy provides equitable care for all patients irrespective of religion	This policy replaces the previous Domestic Abuse policy	None
Disability	This policy provides equitable care for all patients irrespective of disability	This policy replaces the previous Domestic Abuse policy	None
Sexuality	This policy provides equitable care for all patients irrespective of sexuality	This policy replaces the previous Domestic Abuse policy	None
Pregnancy and Maternity	Patients who are pregnant or postnatal are at increased risk of domestic abuse.	This policy replaces the previous Domestic Abuse policy	None
Gender Reassignment	This policy provides equitable care for all patients irrespective of gender	This policy replaces the previous Domestic Abuse policy	None
Marriage and Civil Partnership	This policy provides equitable care for all patients irrespective of marital status; it does acknowledge the patients who are part of a civil partnership and identifies their rights in this area.	This policy replaces the previous Domestic Abuse policy	None

Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	This policy provides equitable care for all patients irrespective of socio-economic status	This policy replaces the previous Domestic Abuse policy	None

What consultation with protected characteristic groups including patient groups have you carried out?

- This policy acknowledges the needs of patients who may disclose domestic abuse or where there are concerns for adults and/or children but also require care from an acute perspective. To ensure that it is complaint with all legislation it has been shared with senior medical and mental health colleagues for consultation and feedback to ensure that it effectively meets the needs of all vulnerable patients.

What data or information did you use in support of this EqIA?

- Browne J (MP) and The RT Honorable Green (MP) (2013) Home Office Crime and policing London, Home Office
- CAADA (2012) A Place of Safety: Insights into Domestic Abuse 1. Bristol
- CAADA (2010) Saving lives, saving money: MARAC's and high domestic abuse: Bristol
- Care and support statutory guidance (2016) Department of Health
- Crime and Disorder Act 1998 section 5-7.
- Department of Health (2005) Responding to Domestic Abuse: a handbook for professionals London DH
- Department of Health (2006) Tackling Health and Mental Health Effects of Domestic and Sexual Violence and Abuse
- Department of Health (2010) The Department of Health Action Plan
- Domestic Violence and Abuse Nottinghamshire Joint Strategic Needs Assessment (2014)
- Department of Health (2015) Safeguarding women and girls at risk of FGM.
- Department of Health (2016) Multiagency statutory guidance on female genital mutilation
- Forced Marriage and Learning Disabilities; Practice Guidelines (2012)
- Forced Marriage: Multi agency practice guidelines (2013)
- HMIC (2014) Nottinghamshire Police's approach to tackling domestic abuse. Inspecting Policing in the Public interest
- Hunt R, Fish J (2008) Prescription for change: lesbian and bisexual women's health check. London: Stonewall
- Improving Safety, Reducing Harm. Children, young people and domestic violence. A practical toolkit for front-line practitioners Department of Health (2009)
- NHS Operating Framework 2011-2012 (Department of Health, 2010)
- NICE (2014) Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE London
- Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08
- Protection of Freedoms Act 2012
- Radford et al (2011) Child Abuse and neglect in the UK today, London, NSPCC
- Ratti A (2012) New domestic abuse guidelines issued by government
- Safelives (2014) Guidance for MARAC: Addressing the abusive behaviour of alleged perpetrators
- Serious Crime Act 2015

- Smith, K Osbourne S, Lau I, & Britton A, (2012) Homicides, Firearm offences and intimate partner violence 2010/2011: Supplementary volume 2 Crime in England and Wales, London
- Statutory Guidance for the conduct of Domestic Homicide Reviews (Home Office, 2011)
- Striking the Balance, Practical guidance on the application of Caldicott Guardian principles to domestic violence and MARACS (multi agency risk assessment conferences) (DoH, 2008)
- The Care Act (2014) Department of Health
- Walker, A Flatley, J. Kershaw, C. AND Moon D. (2009) 'Crime in England and Wales 2008/09: Volume 1-Findings from the British Crime Survey and police recorded Crime'. London: Home Office.
- Working Together to Safeguard Children:(2018)

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- Ensuring that patients are aware of their rights and the legislative requirements that may affect them when they are unwell and require interventions using the Care Act (2014), Working Together to Safeguard Children (2015) Mental Health Act (1983,2003), Mental Capacity Act (2005) or Deprivation of Liberty Safeguards (2007). These have all been acknowledged within this policy and the other supporting policies referenced within this policy.

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Lisa Nixon Safeguarding Lead

Signature:
L Nixon

Date:
20th June 2023