DOMESTIC ABUSE POLICY (PATIENTS)

POLICY

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Date Approved			
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	x		
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Lead Division/ Directorate	Corporate		
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1.0 INTRODUCTION

This policy sets out Sherwood Forest Hospitals NHS Foundation Trust's commitment to recognising, responding to and addressing domestic abuse as a significant safeguarding, public health, workforce and healthcare issues affecting patients, families, carers, visitors and members of staff.

The Trust acknowledges that domestic abuse can have profound and long-lasting impacts on physical health, mental health, emotional wellbeing, safety, housing stability, employment, finances, relationships and social functioning. Domestic abuse is associated with increased risks of injury, chronic illness, substance misuse, self-harm, suicide, exploitation, homelessness, safeguarding concerns and premature mortality.

Domestic abuse may include, but is not limited to:

- physical abuse
- emotional and psychological abuse
- coercive and controlling behavior
- sexual abuse
- economic or financial abuse
- stalking and harassment
- technology-facilitated or digital abuse
- so-called honor-based abuse
- forced marriage
- female genital mutilation (FGM)

The Trust recognises that coercive and controlling behavior can significantly impact an individual's autonomy, independence, safety and ability to seek support. The Trust further recognises the increasing prevalence of technology-facilitated abuse, including online harassment, surveillance, monitoring of communications, location tracking and misuse of digital platforms to intimidate, control or threaten victims and survivors.

Children who see, hear, experience or are exposed to the effects of domestic abuse are recognised as victims in their own right under the Domestic Abuse Act 2021. Children living in households affected by domestic abuse may experience significant emotional, developmental and physical harm and are at increased risk of trauma, mental ill-health, neglect, exploitation, serious injury and future victimisation.

As of 2026, NHS Organisations are expected to operate within strengthened domestic abuse frameworks informed by:

- Domestic Abuse Act 2021
- Care Act 2014
- Working Together to Safeguard Children
- NHS England Safeguarding Accountability and Assurance Framework (SAAF)
- NICE Quality Standard Domestic Violence and Abuse (QS116)
- Violence Against Women and Girls (VAWG) strategic framework
- The cross-government strategy Freedom from Violence and Abuse (2025)

These frameworks require NHS Organisations to adopt a whole-Trust, trauma-informed and person-centered approach to domestic abuse, recognising the responsibility of healthcare providers to:

- identify abuse early
- provide safe and compassionate responses
- safeguard adults and children
- support workforce wellbeing
- work collaboratively with partner agencies
- reduce the risk of serious harm and homicide
- address health inequalities and barriers to support

The Trust recognises that healthcare settings are uniquely placed to identify and respond to domestic abuse, as many victims and survivors may not access other statutory services but will come into contact with healthcare professionals.

The Trust is committed to working collaboratively with safeguarding partnerships, local authorities, police, Integrated Care Boards (ICB), specialist domestic abuse services, MARAC arrangements and voluntary sector organisations across Nottinghamshire to ensure effective safeguarding and coordinated support for adults and children affected by domestic abuse.

National data from the Office for National Statistics indicates that approximately 3.8 million people aged 16 years and over experienced domestic abuse in England and Wales in the year ending March 2025, with women disproportionately affected by high-risk, repeated and coercive forms of abuse. Domestic abuse continues to place significant demand on health services, including emergency care, maternity services, mental health services, primary care and safeguarding systems.

Evidence demonstrates increased prevalence amongst individuals experiencing mental ill-health, substance misuse, disability, homelessness, social exclusion and severe multiple disadvantage. Domestic abuse is strongly associated with adverse childhood experiences, repeated healthcare attendance, mental health crisis presentation, suicide risk, substance dependency and poor long-term health outcomes.

The Trust recognises that domestic abuse can affect any person regardless of age, disability, ethnicity, culture, religion, gender identity, sexual orientation, socioeconomic status or immigration status. The Trust further recognises that some groups may experience additional barriers to disclosure, protection and support, including:

- disabled adults
- older adults
- LGBTQ+ individuals
- individuals from ethnically diverse communities
- migrants and those with insecure immigration status
- individuals experiencing homelessness or severe multiple disadvantages

The Trust is committed to delivering culturally competent, inclusive and equitable care and recognises the importance of understanding the impact of trauma, discrimination, stigma and inequality on an individual's ability to seek help and engage with services.

The Trust acknowledges that domestic abuse is also a workforce issue. Employees may themselves be victims, survivors or perpetrators of domestic abuse, and abuse may significantly impact health, wellbeing, attendance, workplace safety and professional functioning. The Trust is committed to

supporting staff affected by domestic abuse through supportive management practices, safeguarding processes, occupational health services, workforce policies and appropriate referral pathways.

The Trust further recognises that domestic abuse perpetrated by members of staff may pose risks to colleagues, patients, workplace safety and professional conduct. Allegations, concerns or identified risks relating to abusive behavior by employees will be managed appropriately through safeguarding, workforce, professional and disciplinary processes, including consideration of risks associated with misuse of Trust systems, confidential information or professional position.

Legislative and National Framework

This policy should be read in conjunction with current legislation, statutory guidance and national safeguarding frameworks including:

- Domestic Abuse Act 2021
- Care Act 2014
- Children Act 1989 and 2004
- Working Together to Safeguard Children 2026
- Mental Capacity Act 2005
- Human Rights Act 1998
- Equality Act 2010
- Female Genital Mutilation Act 2003
- Serious Crime Act 2015
- NHS England Safeguarding Accountability and Assurance Framework (SAAF)
- NICE Quality Standard QS116 Domestic Violence and Abuse

This policy does not replace professional judgement, safeguarding supervision or consultation with the Trust Safeguarding Team where concerns exist regarding the welfare or safety of an adult, child or member of staff.

2.0 POLICY STATEMENT

Sherwood Forest Hospitals NHS Foundation Trust is committed to promoting best practice in the prevention, recognition, assessment and management of domestic abuse.

The Trust adopts a trauma-informed approach to domestic abuse, recognising that all staff have a responsibility to contribute to the identification, safeguarding and support of individuals affected by abuse.

The Trust is committed to:

- promoting a culture where domestic abuse is recognised, understood and responded to appropriately
- ensuring adults and children affected by domestic abuse receive timely, compassionate and person-centered support
- safeguarding adults and children from abuse, neglect and exploitation
- supporting staff who are experiencing domestic abuse
- working collaboratively with partner agencies to reduce risk and prevent serious harm
- embedding culturally competent and inclusive practice
- supporting early intervention and prevention
- learning from safeguarding reviews, Domestic Abuse Related Death Reviews, PSIRF investigations and multi-agency reviews to improve practice and patient safety

The policy sets out the responsibilities and expectations of all clinical staff to:

- recognise indicators and presentations associated with domestic abuse
- respond appropriately and safely to disclosures
- maintain professional curiosity were injuries, presentations, behaviors, repeated attendances or interactions may indicate domestic abuse, coercive control or safeguarding concerns
- recognise barriers to disclosure and the impact of fear, trauma, stigma, dependency, cultural factors and disguised compliance
- undertake robust risk assessments, including use of DASH (Domestic Abuse, Stalking and Harassment) Risk Assessment where appropriate
- identify and escalate concerns relating to high-risk victims
- support access to specialist domestic abuse services and safeguarding pathways
- contribute to MARAC (Multi-Agency Risk Assessment Conference) processes and safety planning where required
- appropriately share information with safeguarding partners in accordance with legislation and information sharing principles
- maintain accurate, contemporaneous and defensible clinical records
- work in accordance with safeguarding legislation, professional standards and Trust procedures

This clinical policy applies to:

Staff Groups

- Nursing, midwifery, allied health professionals, therapy and medical staff
- All clinical staff caring for adults and/or children where there are concerns regarding domestic abuse or where abuse is disclosed
- Safeguarding practitioners and specialist teams
- Staff working within emergency care, maternity, pediatrics, mental health liaison, outpatient and inpatient settings

Clinical Areas

- All clinical areas and departments within the Trust

Patient Groups

- All adults, children and young people presenting to the Trust who are experiencing, witnessing or impacted by domestic abuse
- Adults at risk and children requiring safeguarding intervention related to domestic abuse

Exclusions

- No exclusions.

3.0 DEFINITIONS/ ABBREVIATIONS

Domestic Abuse:
For the purpose of this policy, Sherwood Forest Hospitals NHS Foundation Trust adopts the definition of domestic abuse contained within the Domestic Abuse Act 2021.

Domestic abuse is defined as:

"Any incident or pattern of incidents between individuals aged 16 years or over who are personally connected to each other, which may consist of physical or sexual abuse, violent or threatening behavior, controlling or coercive behavior, economic abuse, psychological, emotional or other abuse."

The behavior may consist of a single incident or a course of conduct and can occur regardless of gender, sexuality, ethnicity, religion, disability, age, socioeconomic status or immigration status.

The behavior may consist of a single incident or a course of conduct and can occur regardless of gender, sexuality, ethnicity, religion, disability, age, socioeconomic status or immigration status.

The Domestic Abuse Act 2021 recognises children who see, hear, experience or are exposed to the effects of domestic abuse as victims in their own right.

A person is "personally connected" if they:

- are, or have been, married to each other
- are or have been civil partners
- have agreed to marry one another
- are or have been in an intimate personal relationship
- have, or have had, a parental relationship in relation to the same child
- are relatives

Domestic abuse can encompass, but is not limited to:

- physical abuse
- sexual abuse
- emotional or psychological abuse
- coercive or controlling behavior
- economic or financial abuse
- stalking and harassment
- technology-facilitated or digital abuse
- so-called honor-based abuse
- forced marriage
- female genital mutilation (FGM)

The Trust recognises that domestic abuse is often characterised by repeated patterns of behavior intended to gain power, control or dominance over another person and may occur alongside safeguarding concerns relating to children and adults at risk.

Controlling Behavior
Controlling behavior is defined as:

"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 behavior."

Controlling behavior may include:

- isolating an individual from family, friends or support services
- monitoring movements, communication or social activity
- controlling access to finances, medication, transport or technology
- restricting freedom, independence or decision-making
- intimidation, humiliation or degradation
- regulating day-to-day activities

Coercive Behavior
Coercive behavior is defined as:

"An act or a pattern of acts of assault, threats, humiliation, intimidation or other abuse used to harm, punish or frighten another person."

Coercive control may involve ongoing patterns of manipulation, surveillance, intimidation or degradation and may significantly impact a victim's confidence, autonomy, mental health and ability to seek help or leave an abusive relationship.

The Serious Crime Act 2015 introduced the criminal offence of controlling or coercive behavior in an intimate or family relationship.

Economic Abuse
Economic abuse is recognised within the Domestic Abuse Act 2021 and refers to behavior that has a substantial adverse effect on a person's ability to:

- acquire, use or maintain money or property
- obtain goods or services
- maintain financial independence or economic stability

Examples may include:

- controlling access to bank accounts or wages
- preventing a person from working or studying
- creating debt in another person's name
- withholding money, food, medication or essential items
- exploiting financial resources

Stalking and Harassment
Stalking is a pattern of repeated, fixated, obsessive or unwanted behavior directed towards another person which causes fear, distress or alarm.

Harassment may involve repeated unwanted contact, behavior or conduct intended to intimidate, distress or control another person.

Examples may include:

persistent unwanted communication by telephone, text, email or social media:

- repeated following, monitoring or surveillance

- attending a person's home, workplace or other uninvited locations
- sending unwanted gifts or messages
- damaging property
- making threats or intimidating behavior
- monitoring online activity or digital communications

The Trust recognises that stalking behavior may escalate rapidly and is associated with increased risk of serious harm and homicide.

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	Honour-based abuse refers to incidents or crimes committed to protect or defend the perceived honor of an individual, family or community. This may include: • forced marriage • physical abuse • emotional or psychological abuse • coercive control • threats, intimidation or isolation • restriction of liberty • sexual violence or homicide The Trust recognises that honor-based abuse can affect adults and children of any gender.
Female Genital Mutilation (FGM)	Female Genital Mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is illegal in the United Kingdom and is recognised as a serious form of child abuse and violence against women and girls. Healthcare professionals must comply with mandatory reporting duties relating to FGM in accordance with national legislation and safeguarding procedures.

Forced Marriage	Forced marriage is a marriage conducted without the valid and freely given consent of one or both parties and may involve physical, emotional, psychological, sexual or financial pressure or abuse. Forced marriage is a criminal offence and differs from arranged marriage, where both parties freely consent.
Technology-Facilitated or Digital Abuse	Technology-facilitated abuse refers to the misuse of digital technology, online platforms, communication devices or surveillance systems to control, monitor, harass, threaten or intimidate another person. Examples may include: • monitoring phones, emails or social media accounts • location tracking through devices or applications • repeated unwanted messaging or online harassment • sharing intimate images without consent • use of spyware, smart devices or surveillance equipment • impersonation or online humiliation
Think Family	Think Family approach helps to provide responses to the most vulnerable families and reduce intergenerational 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	DASH (Domestic Abuse, Stalking and Harassment) is a nationally recognised risk assessment tool designed to identify and assess risks associated with domestic abuse, stalking, harassment, and honour-based abuse. It supports professionals in identifying the level of risk faced by victims, informing safeguarding measures, and ensuring appropriate support and intervention are provided.
DARDR	Domestic Abuse Related Death Reviews (DARDRs) are multi-agency reviews undertaken following the death of an individual aged 16 or over where domestic abuse is known or suspected to have been a contributing factor, in accordance with the Domestic Violence, Crime and Victims Act 2004. The purpose of these reviews is to identify lessons from agency involvement, highlight any systemic issues or missed opportunities, and improve inter-agency responses to help prevent similar deaths in the future.

MARAC	MARAC (Multi-Agency Risk Assessment Conference) is a multi-agency forum where professionals from relevant agencies share information about high-risk domestic abuse cases. The purpose of MARAC is to enhance victim safety, reduce the risk of further harm, and coordinate effective safeguarding and support plans for victims, children, and their families.
MAPPA	Multi-Agency Public Protection Arrangements (MAPPA) are the statutory arrangements in England and Wales through which the responsible authorities work together to manage registered sex offenders, violent offenders, and other individuals who pose a serious risk of harm to the public. The aim of MAPPA is to assess and manage risk effectively, enhance public protection, and support coordinated multi-agency risk management plans.
Routine Enquiry	Is the practice of asking all individuals accessing services about their experiences of domestic abuse or violence, regardless of whether there are any visible indicators, disclosures, or suspicions of abuse. The aim is to identify individuals who may be experiencing abuse, provide opportunities for disclosure, and ensure appropriate support and safeguarding interventions are offered.
Selective Enquiry	Is the practice of directly asking individuals accessing services about their experiences of domestic abuse or violence when there are identified concerns, suspicions, or indicators that abuse may be occurring. The purpose is to explore potential risks, facilitate disclosure, and ensure appropriate support and safeguarding measures are considered.
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: An adult at risk may be a person who: • Is elderly and frail due to ill health • Has a learning disability • Has physical disability and / or a sensory impairment • Have 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
- **DARDR** – Domestic Abuse Related Death Review
- **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 an individual uses or takes advantage of another person for their own benefit or gain.
- **NWAL** – Nottinghamshire Women's Aid

4.0 ROLES AND RESPONSIBILITIES

Sherwood Forest Hospitals NHS Foundation Trust recognises that responding effectively to domestic abuse requires a whole-Trust, multi-agency and trauma-informed approach. All staff have a responsibility to contribute to the prevention, recognition, assessment and management of domestic abuse in accordance with safeguarding legislation, professional standards and Trust policies.

4.1 Trust Board

The Trust Board has overall accountability for ensuring that robust systems, governance arrangements and safeguarding processes are in place to support the effective identification and management of domestic abuse across the organisation.

The Trust Board is responsible for:

- ensuring the Trust meets its statutory safeguarding duties relating to adults and children
- ensuring compliance with the Domestic Abuse Act 2021, Care Act 2014 and Working Together to Safeguard Children 2026
- promoting a culture of safety, safeguarding, trauma-informed practice and professional curiosity

- ensuring appropriate assurance, governance and reporting mechanisms are in place
- supporting lawful and proportionate information sharing where there is a safeguarding concern, risk of serious harm or public protection requirement
- ensuring sufficient resources, training and workforce support arrangements are available to enable staff to fulfil their safeguarding responsibilities
- seeking assurance regarding compliance, training, audit activity, learning from Domestic Abuse Related Death Reviews, safeguarding reviews, PSIRF investigations and multi-agency learning

The Trust Board will receive assurance regarding domestic abuse safeguarding activity through safeguarding governance structures including audit activity, safeguarding assurance reports, training compliance, Domestic Abuse Related Death Review learning and quality improvement activity.

4.2 Chief Executive

The Chief Executive will ensure appropriate Executive Lead accountability arrangements are in place for domestic abuse and safeguarding.

The Chief Executive is responsible for ensuring that:

- the Trust fulfils its statutory safeguarding responsibilities relating to adults and children
- appropriate governance, policies and reporting arrangements are in place
- effective systems exist to support safeguarding practice, information sharing and partnership working
- domestic abuse is appropriately embedded within organisational safeguarding, patient safety and workforce wellbeing arrangements
- staff are supported to respond effectively to domestic abuse concerns
- the organisation works collaboratively with safeguarding partnerships, MARAC arrangements and partner agencies to reduce the risk of serious harm

Operational responsibility may be delegated to Executive Leads and Designated Safeguarding Professionals; however, overall accountability remains with the Chief Executive.

4.3 Information Governance Officer

The Information Governance Lead and/or Data Protection Officer is responsible for supporting lawful, proportionate and appropriate information sharing in relation to domestic abuse and safeguarding concerns.

4.4 Divisional Managers / Heads of Departments

Divisional Directors, Managers and Heads of Department are responsible for ensuring that staff within their services understand and fulfil their responsibilities in relation to domestic abuse.

4.5 Line Managers:

Line managers are responsible for supporting staff to understand and fulfil their safeguarding responsibilities in relation to domestic abuse.

4.6 All Staff employed by Sherwood Forest Hospitals

All staff employed by the Trust have a responsibility to:

- familiarise themselves with this policy and associated safeguarding procedures
- maintain awareness of domestic abuse indicators, presentations and risk factors
- respond appropriately and safely to disclosures or concerns relating to domestic abuse
- maintain professional curiosity were presentations, behaviors, injuries, repeated attendances or

interactions may indicate abuse, coercive control or safeguarding concerns
- recognise barriers to disclosure, including fear, trauma, stigma, dependency, disability, language barriers and cultural factors
- undertake safeguarding actions in accordance with Trust policies and procedures
- seek advice from safeguarding professionals where required
- accurately document concerns, disclosures, assessments and actions taken
- appropriately share information in accordance with safeguarding legislation, professional standards and information governance requirements
- consider the safeguarding needs of any child or adult at risk who may be affected by domestic abuse
- make safeguarding referrals where concerns meet statutory or organisational thresholds

All staff are expected to work in accordance with:

- Domestic Abuse Act 2021
- Care Act 2014
- Working Together to Safeguard Children 2026
- Mental Capacity Act 2005
- Human Rights Act 1998
- relevant professional codes of conduct and safeguarding guidance

4.7 Hospital Independent Domestic Violence Advisor (HIDVA)

The Hospital Independent Domestic Violence Advisor (HIDVA) or Domestic Abuse Specialist Practitioner provides specialist expertise, leadership, advice and support to the Trust in relation to domestic abuse.

The role includes:

- providing specialist advice, consultation and support to staff managing domestic abuse concerns
- supporting robust risk identification, assessment and safety planning
- contributing to safeguarding decision-making relating to adults, children and families affected by domestic abuse
- supporting use of the DASH (Domestic Abuse, Stalking and Harassment) Risk Assessment where appropriate
- supporting identification and escalation of high-risk cases
- liaising with external agencies, including:

  - MARAC
  - police
  - local authorities
  - safeguarding partnerships
  - specialist domestic abuse services
  - mental health services

- promoting trauma-informed, person-centered and culturally competent practice across the organisation
- supporting staff training, awareness raising and service development
- contributing to policy development, governance activity and quality improvement initiatives
- supporting learning from safeguarding reviews, Domestic Abuse Related Death Reviews and multi-agency reviews
- supporting robust documentation, confidentiality and lawful information sharing processes

- supporting development and review of referral pathways and escalation procedures
- providing representation for the Trust within relevant multi-agency domestic abuse and safeguarding forums, including MARAC arrangements where appropriate

The IDVA/Domestic Abuse Specialist Practitioner will work collaboratively with the Trust Safeguarding Team to ensure that safeguarding responses are proportionate, evidence-based, legally compliant and focused on reducing the risk of serious harm.

5.0 APPROVAL

Approval is through the Safeguarding Committee.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

6.1 Understanding why people may not disclose

Survivors experiencing domestic abuse may find it difficult to disclose abuse for a variety of complex and interconnected reasons. Healthcare professionals must recognise that disclosure is often a process rather than a single event and that fear, trauma and coercive control can significantly affect an individual's ability to seek help.

Barriers to disclosure may include:

- fear of retaliation, escalation of abuse or serious harm
- fear of not being believed
- shame, embarrassment, stigma or self-blame
- emotional attachment to, or dependency on, the perpetrator
- fear of family separation or involvement of statutory agencies
- financial dependence or economic abuse
- immigration concerns or fear relating to insecure immigration status
- previous negative experiences with services
- cultural, religious or community pressures
- disability, communication or learning needs
- concerns regarding confidentiality
- fear of discrimination or prejudice
- trauma responses, including minimisation, dissociation or avoidance
- concern for children, pets or other family members

The Trust recognises that individuals may present repeatedly to healthcare services before disclosing abuse and that professionals should maintain professional curiosity where there are indicators of domestic abuse, coercive control or safeguarding concerns.

Healthcare professionals may also experience anxiety about asking about domestic abuse, including concerns about causing offence, managing disclosures, saying the wrong thing or not knowing what action to take. The Trust recognises the importance of training, safeguarding supervision and access to specialist advice to support staff confidence and competence.

6.2 Preparing to Ask About Domestic Abuse

Healthcare environments should promote safe opportunities for disclosure and demonstrate that domestic abuse is recognised as a health and safeguarding issue.

Clinical areas should:

- display accessible domestic abuse information and support resources where safe and appropriate
- promote inclusive and culturally competent messaging
- support trauma-informed and person-centered practice
- provide access to interpreters, advocacy services and communication support where required

Before asking about domestic abuse, staff must:

- ensure it is safe and appropriate to ask
- consider immediate risks to the individual and others
- ensure privacy and confidentiality as far as possible
- clearly explain the purpose of asking
- explain the limits of confidentiality, including safeguarding responsibilities
- avoid assumptions that another professional or service is addressing the concern
- consider cultural, communication, disability and language needs
- consider whether the individual may be experiencing coercion, surveillance or technology-facilitated abuse

Where possible and appropriate, individuals should be offered a worker or interpreter that meets their communication, cultural or gender-related preferences.

6.2 Creating a Safe Environment for Disclosure

Staff should create opportunities for individuals to speak confidentially and safely about their experiences.

Individuals should not routinely be asked about domestic abuse in the presence of:

- partners
- family members
- friends
- carers who may be involved in the abuse
- children

The use of family members, friends or children as interpreters is not acceptable and may place the individual at increased risk.

Where communication barriers exist, staff must use:

- professional interpreting services
- accessible communication methods
- trained advocacy services
- Learning disability support services where appropriate

Staff should remain aware that perpetrators may:

- accompany individuals to healthcare appointments
- seek to control conversations
- monitor communications or devices
- attempt to prevent disclosure

Professionals should assess the potential risks and benefits of separating an individual from accompanying persons and should seek safeguarding advice where concerns exist regarding safety.

6.3 Developing a Trauma-Informed and Empowering Response

Many individuals experiencing domestic abuse report positive experiences when healthcare professionals ask sensitively about abuse.

Staff should recognise that:

- individuals always have the right not to disclose
- asking about abuse can increase feelings of safety and validation
- a healthcare professional may be the first or only person to ask
- disclosure may occur gradually over time
- denial of abuse does not necessarily mean abuse is not occurring

If an individual does not disclose abuse but concerns remain, staff should:

- maintain professional curiosity
- continue to provide opportunities for future discussion
- offer information about support services where it is safe to do so
- document concerns appropriately
- consider safeguarding actions were indicated

Staff should adopt a trauma-informed approach that:

- avoids judgement or blame
- promotes safety, choice and empowerment
- recognises the impact of trauma and coercive control
- supports dignity and respect
- acknowledges barriers to disclosure and engagement

6.4 Asking About Domestic Abuse ("Making an Enquiry")

Where there are indicators, concerns or risk factors relating to domestic abuse, staff should sensitively and appropriately ask direct questions.

Staff should:

- explain why they are asking
- use clear, simple and non-judgmental language
- avoid terminology that may not be understood
- reassure the individual that support is available
- explain confidentiality and safeguarding responsibilities
- respond calmly and empathetically

Best practice is for the individual to be seen alone where safe and appropriate to do so.

Staff must never routinely raise concerns regarding domestic abuse in front of:

- partners
- relatives
- friends
- children

Exceptions may include:

- professional interpreters
- appropriately trained advocates
- individuals supporting communication needs where risk has been assessed

Where domestic abuse is disclosed or suspected, staff should consider:

- current and historical risk
- escalation of abuse
- coercive control and stalking behaviors
- immediate safety concerns
- risks to children or adults at risk
- pregnancy
- mental health and suicide risk
- substance misuse
- access to weapons
- threats to kill
- strangulation or suffocation
- separation from perpetrator
- Technology-facilitated abuse
- homelessness or housing risk

All assessments, disclosures and actions must be clearly documented within the healthcare record, including date, time, factual observations and actions taken.

Staff should consider use of the DASH (Domestic Abuse, Stalking and Harassment) Risk Assessment where appropriate and seek safeguarding or specialist advice in high-risk or complex cases.

Examples of supportive and direct questions may include:

- “I am concerned about some of the things you have described. Is someone hurting or frightening you?”
- “Do you feel safe at home?”
- “Has your partner, ex-partner or another person ever controlled, threatened or harmed you?”
- “Has anyone prevented you from seeing friends, family or accessing money or support?”
- “Has anyone monitored your phone, online activity or movements in a way that makes you feel unsafe?”
- “Are you frightened of anyone at home or in your personal relationships?”

Where injuries or presentations are inconsistent with explanations provided, professionals should respond honestly, sensitively and professionally while maintaining a non-judgmental approach.

- 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?

Listening, Validating and Responding Appropriately

Listening to and validating an individual's experiences is essential in building trust, reducing isolation and supporting safety.

Appropriate responses may include:

- "Thank you for telling me."
- "I am glad you felt able to speak to me."
- "You are not to blame for what is happening."
- "You do not deserve to be treated this way."
- "Support is available."
- "You are not alone."

Staff should:

- take all disclosures seriously
- assess and respond to immediate risk
- prioritise the safety of adults and children
- avoid victim-blaming language or attitudes
- avoid pressuring individuals to leave abusive relationships
- support informed decision-making and safety planning
- consider safeguarding responsibilities relating to children and adults at risk
- share information appropriately and lawfully where safeguarding concerns exist
- refer or signpost to specialist support services where appropriate

Documentation relating to domestic abuse may form part of:

- safeguarding processes
- MARAC discussions
- criminal investigations
- court proceedings
- Domestic Abuse Related Death Reviews
- serious case reviews or safeguarding reviews

Accurate, objective and contemporaneous documentation is therefore essential.

6.5 Safety Considerations and Safety Planning

The safety of adults, children and staff must remain central to all domestic abuse responses.

Staff must:

- prioritise immediate and ongoing safety
- avoid actions that may increase risk
- consider the potential impact of information sharing or contact with the perpetrator
- avoid collusion with abusive behavior or coercive control
- support individuals to access specialist domestic abuse services and safeguarding support
- consider safe methods of communication and follow-up
- assess risks relating to discharge, transport, accommodation and ongoing contact with perpetrators

Where high-risk domestic abuse is identified, staff should:

- seek immediate safeguarding advice
- consider referral to MARAC
- implement safety planning measures
- escalate concerns appropriately in accordance with safeguarding procedures

The Trust recognises that leaving an abusive relationship may significantly increase the risk of serious harm or homicide and that safety planning must be individualised, trauma-informed and proportionate to the identified risks. 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 patient to do anything in the first instance, just offer support that the patient has disclosed and identify any safeguarding risks to children.

If the patient is not at immediate risk/danger, discuss the options that are available with the patient, provide access to the telephone for the opportunity to contact the Police or other services themselves.

If an individual is identified as a vulnerable adult, defined as someone who is or may be in need of community care services due to mental or physical disability, age, or illness, and who may be unable to care for themselves or protect themselves from significant harm or exploitation, staff must consider their safety and wellbeing. This should include discussion with the Trust Safeguarding Team and consideration of a referral to Adult Social Care for further assessment. Any actions taken, decisions made, and outcomes must be clearly documented in the individual's records.

6.6 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.

6.7 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 they 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

6.8 Working with male victims of Domestic Abuse

The Trust recognises that men can experience domestic abuse and may face additional barriers to disclosure, recognition and access to support. Domestic abuse affecting men may include physical abuse, coercive control, emotional abuse, sexual abuse, economic abuse, stalking and technology-facilitated abuse.

Male victims and survivors may be less likely to disclose abuse due to:

- stigma or embarrassment
- fear of not being believed or taken seriously
- concerns regarding masculinity, identity or shame
- fear of judgement or discrimination
- lack of awareness of available support services
- fear of repercussions relating to children, housing or relationships
- previous negative experiences with services

The Trust recognises that men experiencing domestic abuse may present differently within healthcare settings and may be more likely to seek informal or online support before engaging with statutory or healthcare services.

Healthcare professionals must:

- avoid assumptions regarding gender roles or perpetrator/victim dynamics
- provide the same professional curiosity, safeguarding response and compassionate support offered to all victims and survivors
- ensure assessments remain trauma-informed, person-centered and evidence-based
- recognise that abuse may occur within heterosexual and same-sex relationships
- consider barriers to disclosure and engagement when assessing risk and support needs

All disclosures or concerns relating to domestic abuse involving male victims and survivors must be responded to appropriately in accordance with this policy, safeguarding procedures and risk assessment processes, including consideration of risks to children and adults at risk.

Within Nottinghamshire, specialist support services are available for men experiencing domestic abuse, including community-based advocacy, emotional support, safety planning and support for individuals assessed as standard, medium or high risk. Staff should refer or signpost individuals to appropriate local and national domestic abuse services in accordance with current referral pathways and commissioning arrangements.

The Trust recognises the importance of inclusive practice and ensuring that all victims and survivors of domestic abuse, regardless of gender identity or sexual orientation, can access safe, equitable and supportive healthcare responses.

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**

6.9 Domestic violence/abuse and safeguarding children

The Trust recognises that domestic abuse can have a significant impact on the safety, wellbeing, development and long-term outcomes of children and young people.

Children and young people may experience harm both directly and indirectly where domestic abuse occurs within the household or family environment. Exposure to domestic abuse can negatively affect emotional wellbeing, attachment, development, behaviors, education, physical health and mental health and may increase vulnerability to exploitation, substance misuse, self-harm and future abusive relationships.

Under the Domestic Abuse Act 2021, children who see, hear, experience or are exposed to the effects of domestic abuse are recognised as victims in their own right.

Domestic abuse should therefore always be considered a potential safeguarding concern where:

- a child or young person resides in, visits or is connected to a household where domestic abuse is occurring
- a child witnesses abuse, coercive control, intimidation or threats
- a child is exposed to the emotional impact or consequences of abuse
- there are concerns regarding parenting capacity, neglect or emotional harm

- there are indicators of cumulative harm, trauma or risk escalation

Healthcare professionals must consider the lived experience of the child and maintain professional curiosity regarding the impact of domestic abuse on the child's safety and wellbeing.

Where domestic abuse is identified or suspected and a child may be at risk of harm, neglect or significant impairment of health or development, staff must:

- follow Trust safeguarding children's procedures
- seek advice from the Safeguarding Team where required
- make appropriate referrals to Children's Social Care and/or safeguarding services
- document concerns, disclosures, observations and actions clearly within the healthcare record
- consider the need for information sharing with partner agencies in accordance with safeguarding legislation and local procedures

The safety and welfare of the child must remain paramount at all times.

The Trust also recognises that children and young people may experience domestic abuse within their own intimate relationships, including:

- coercive and controlling behavior
- emotional or psychological abuse
- physical or sexual violence
- stalking and harassment
- technology-facilitated abuse
- exploitation
- so-called honor-based abuse
- forced marriage
- female genital mutilation (FGM)

Adolescents and young adults may face additional barriers to recognising abuse and accessing support, and healthcare professionals should respond sensitively and appropriately to disclosures or concerns.

Where appropriate, staff should utilise recognised risk assessment processes, including age-appropriate domestic abuse and safeguarding assessment tools, and seek specialist safeguarding advice in complex or high-risk cases.

Staff should access current referral pathways, safeguarding guidance and domestic abuse risk assessment documentation via the Trust safeguarding intranet pages or by contacting the Trust Safeguarding Team.

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

6.10 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 in fact cared for by the perpetrator. Due to health 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 should also take appropriate steps to act in the individual's best interests where the victim or perpetrator is assessed as lacking the mental capacity to make relevant decisions.

6.11 Older People with Dementia

The Trust recognises that older adults, including people living with dementia, may be at increased risk of domestic abuse, neglect, coercive control, financial abuse and exploitation within family, intimate partner or caregiving relationships. Abuse may be perpetrated by partners, relatives, carers or others in positions of trust and can include psychological or emotional abuse, coercive or controlling behavior, physical or sexual abuse, neglect and financial or economic exploitation.

Cognitive impairment, communication difficulties, dependency on others, frailty and social isolation may make abuse more difficult to identify, disclose or assess. Indicators of abuse may be overlooked or incorrectly attributed to dementia, illness or the ageing process. Healthcare professionals should therefore maintain professional curiosity and undertake careful, person-centered and trauma-informed assessments.

Potential indicators may include unexplained injuries, deterioration in physical or mental health, fearfulness, distress, withdrawal, changes in behavior or presentation, poor living conditions, concerns regarding finances or medication and signs of carer stress, burnout or escalating conflict within caregiving relationships.

The Trust recognises that carers may themselves require support and that unmet support needs, social isolation, mental ill-health and carer stress may contribute to increased safeguarding risks. However, carer stress does not justify abusive or neglectful behavior.

Staff must consider domestic abuse and safeguarding risks when assessing older adults and people living with dementia, including risks relating to coercive control, financial exploitation and neglect. Staff should consider the individual's mental capacity and ability to consent in accordance with the Mental Capacity Act 2005 and seek safeguarding advice where concerns exist. Appropriate safeguarding referrals must be made in accordance with Trust and multi-agency safeguarding procedures.

The Trust recognises the importance of early identification, multi-agency working and timely access to health, social care, safeguarding and carer support services in reducing the risk of harm and promoting the safety and wellbeing of older adults and people living with dementia.

6.12 Adolescents to Parent Violence

Adolescents to Parent Violence and Abuse (APVA) refers to a pattern of abusive, coercive, controlling or violent behavior by a child or young person towards a parent, caregiver or other family member. The abuse may be physical, emotional, psychological, verbal, financial or technology-facilitated and is often characterised by intimidation, threats, coercion, property damage or behaviors intended to exert power and control within the family environment.

The Trust recognises that APVA is a complex safeguarding issue that may coexist with trauma, adverse childhood experiences, neurodevelopmental conditions, mental ill-health, exploitation, family conflict, domestic abuse, substance misuse or unmet emotional and social needs. APVA should therefore be understood within the wider context of safeguarding, child welfare and family functioning.

Whilst there is no specific standalone legal definition of APVA, behaviors may fall within the definitions of domestic abuse, child safeguarding concerns, assault, coercive or controlling behavior, criminal damage or other offences under current legislation, including the Domestic Abuse Act 2021, Children Act 1989 and Working Together to Safeguard Children 2026.

The Trust recognises that APVA is often underreported due to fear, stigma, shame, parental guilt or concerns regarding criminalisation of children and young people. Parents and carers experiencing APVA may themselves require safeguarding support, emotional support and multi-agency intervention.

Healthcare professionals should maintain professional curiosity where there are indicators of APVA, including:

- escalating aggression or intimidation within the home
- parental fearfulness or distress
- repeated injuries or presentations
- family breakdown or crisis
- controlling or threatening behavior by a child or adolescent
- significant emotional harm within family relationships

Staff should undertake trauma-informed and person-centered assessments, consider safeguarding risks to both the child and parent/carer and seek safeguarding advice where concerns are identified. Appropriate referrals should be made in accordance with Trust safeguarding procedures and local multi-agency safeguarding arrangements.

6.13 Disability

The Trust recognises that disabled people are at increased risk of domestic abuse, coercive control, exploitation, and safeguarding harm. Abuse may be perpetrated by intimate partners, family members, carers, personal assistants, or others in positions of trust and may include physical, emotional, sexual, financial, or psychological abuse, neglect, coercive control, and technology-facilitated abuse.

Disabled people may experience prolonged or repeated abuse and may face additional barriers to recognising, disclosing, or escaping abuse due to communication difficulties, social isolation, dependency on others for care, cognitive impairment, financial dependency, or limited access to support services. The Trust also recognises that indicators of abuse may be overlooked or incorrectly attributed to disability, illness, or behaviors that challenge.

Healthcare professionals must adopt a person-centered, trauma-informed, and accessible approach when assessing disabled adults and children. Staff should consider communication, cognitive and sensory needs, ensure information is accessible and avoid using family members or carers as interpreters where abuse is suspected. Staff must also consider issues relating to coercive control, dependency, restrictive practices, and safeguarding risks, including the individual's mental capacity in accordance with the Mental Capacity Act 2005.

Where concerns regarding domestic abuse or safeguarding are identified, staff must follow Trust safeguarding procedures, seek specialist advice where required and make appropriate safeguarding referrals in line with local multi-agency safeguarding arrangements.

6.14 LGBTQ+

The Trust recognises that LGBTQ+ individuals may experience domestic abuse, coercive control and safeguarding harm within intimate, family, or caregiving relationships. Abuse may occur regardless of sexual orientation, gender identity or relationship type and can include physical, emotional, psychological, sexual, financial, and technology-facilitated abuse.

LGBTQ+ individuals may experience additional barriers to recognising, disclosing, or accessing support due to fear of discrimination, stigma, previous negative experiences of services, social isolation, concerns regarding confidentiality or fear of being "outed" to family, communities, employers, or others without consent. The Trust recognises that abusive behaviors may specifically target an individual's sexual orientation or gender identity and may include threats of disclosure, humiliation, identity-based abuse, restriction from LGBTQ+ support networks or undermining a person's identity, autonomy, or sense of safety.

The Trust further recognises that transgender and non-binary individuals may experience abuse linked to their gender identity or gender expression. This may include refusal to use correct names or pronouns, controlling access to gender-affirming care or medication, threats relating to disclosure of gender history, body shaming, humiliation or attempts to undermine a person's identity or credibility.

Healthcare professionals must not make assumptions regarding gender roles, sexuality, perpetrator dynamics, or relationship presentation and should remain aware that domestic abuse can occur within same-sex and LGBTQ+ relationships. Staff should adopt a trauma-informed, person-centered, and culturally competent approach and ensure individuals are treated with dignity, respect and inclusivity in accordance with the Equality Act 2010, Domestic Abuse Act 2021 and NHS safeguarding principles.

Where domestic abuse is identified or suspected, staff must assess risk appropriately, consider safeguarding responsibilities and support access to specialist domestic abuse and LGBTQ+ support services where appropriate. Staff should seek safeguarding advice in complex or high-risk cases and utilise current Trust referral pathways and risk assessment tools available via the safeguarding intranet or Safeguarding Team.

6.12 Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) comprises all procedures involving partial or total removal of, or injury to, the external female genitalia for non-medical reasons. FGM is recognised as a serious form of physical and emotional abuse, violence against women and girls and child abuse.

FGM is illegal in the United Kingdom under the Female Genital Mutilation Act 2003, as amended by the Serious Crime Act 2015. It is a criminal offence to perform FGM, assist or facilitate FGM, including arranging for a child or young person to be taken abroad for the purpose of FGM.

FGM can have significant lifelong physical, psychological, sexual and reproductive health consequences. The Trust recognises that safeguarding women and girls from FGM must be undertaken in a sensitive, trauma-informed and culturally competent manner. FGM is not a religious requirement, and safeguarding action should focus on the safety and wellbeing of the individual.

Healthcare professionals have a mandatory duty to report known cases of FGM in individuals under 18 years of age directly to the police in accordance with statutory guidance. A report must be made where a healthcare professional either:

- is informed by a child that they have undergone FGM, or
- observes physical signs which appear to show that FGM has been carried out and has no reason to believe the procedure was necessary for physical or mental health purposes

In addition to the mandatory reporting duty, staff must follow Trust safeguarding procedures, consider risks to siblings or other children and make appropriate safeguarding referrals in accordance with local multi-agency safeguarding arrangements.

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 Hospital Independent Domestic Violence Advisor (HIDVA) 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 perpetrator
- 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 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 behavior 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 has done the right thing by reporting the issue, and that there is help available. Discuss with them whether they have 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 patients are able to access information about what help is available. This can be done by ensuring that all regards/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 Abuse Related Death 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 Committee and Patient Safety Quality Board for Safeguarding and relevant Governance assurance processes.

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

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 abuse related death reviews and report to the Trust Safeguarding Committee.

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 (e.g. verbal, formal report etc.) and by who)**
Completion of DASH assessment and referral to MARAC	Named Professional for Safeguarding Adults	Audit	yearly	Safeguarding Committee

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

National Legislation and Statutory Guidance

- Care Act 2014
- Children Act 1989 and Children Act 2004
- Crime and Disorder Act 1998
- Data Protection Act 2018
- Domestic Abuse Act 2021
- Equality Act 2010
- Female Genital Mutilation Act 2003
- Forced Marriage (Civil Protection) Act 2007
- Health and Care Act 2022
- Human Rights Act 1998
- Mental Capacity Act 2005
- Modern Slavery Act 2015
- Protection from Harassment Act 1997
- Protection of Freedoms Act 2012
- Serious Crime Act 2015
- Working Together to Safeguard Children 2026
- UK General Data Protection Regulation (UK GDPR)

National Guidance and Professional Frameworks

- HM Government (2025) Freedom from Violence and Abuse Strategy
- Home Office (2022) Domestic Abuse Act 2021 Statutory Guidance
- Home Office (current version) Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
- Home Office (current version) Controlling or Coercive Behavior Statutory Guidance
- NHS England (current version) Safeguarding Accountability and Assurance Framework (SAAF)
- NHS England (current version) Intercollegiate Document: Safeguarding Children and Young People – Roles and Competencies for Healthcare Staff
- NHS England (current version) Safeguarding Adults: Roles and Competencies for Healthcare Staff
- NHS England (current version) Violence Prevention and Reduction Standard
- NICE Guideline NG116: Domestic Violence and Abuse: Multi-agency Working

- NICE Quality Standard QS116: Domestic Violence and Abuse
- NICE Guideline NG76: Child Abuse and Neglect
- Royal College of Nursing (RCN) guidance relating to domestic abuse and safeguarding
- SafeLives (current version) MARAC Operational Guidance
- SafeLives (current version) DASH Risk Identification Checklist Guidance
- Department of Health and Social Care (current version) Safeguarding Women and Girls at Risk of FGM
- HM Government (current version) Multi-Agency Statutory Guidance on Female Genital Mutilation
- HM Government (current version) Forced Marriage Multi-Agency Practice Guidelines
- Caldicott Principles
- Information Sharing Advice for Safeguarding Practitioners (HM Government)

Evidence and Research

- Office for National Statistics (ONS) domestic abuse datasets and publications
- Domestic Abuse Commissioner publications and reports
- NSPCC publications relating to domestic abuse and child safeguarding
- SafeLives national insights and domestic abuse data reports
- Public Health England / Office for Health Improvement and Disparities publications relating to violence against women and girls and domestic abuse
- Relevant Domestic Abuse Related Death Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews

Related SFHFT Policies and Documents

- Safeguarding Adults Policy
- Safeguarding Children Policy
- Workforce Domestic Abuse Policy
- Information Sharing and Confidentiality Policy
- Mental Capacity Act Policy
- Prevent Policy
- Equality, Diversity and Inclusion Policy
- Violence Prevention and Reduction Policy
- Lone Worker Policy
- Incident Reporting Policy
- PSIRF Policy
- Consent to Treatment Policy
- Record Keeping and Documentation Standards Policy
- Relevant Nottinghamshire Safeguarding Partnership Procedures
- MARAC referral pathways and local multi-agency procedures
- Policy for the Management of Violence and Aggression at Sherwood Forest Hospitals NHS Foundation Trust
- 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, 'honor violence'.

Physical effects are often inflicted on areas of the body that are covered and hidden e.g. 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 behavior 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 be 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
- Patients try to hide injuries or minimise their extent
- Partners are aggressive or dominant, talk to the patient or refuse to leave the room when asked
- Partner always accompanies patient for no apparent reason
- Patients are submissive and/or reluctant to speak in front of partner; they appear frightened, overly anxious or depressed
- Patients present 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 behavior problems or unexplained injuries or abuse affecting children
- Suicide attempts
- History of repeat miscarriages, terminations, still births or pre-term labor
- 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 patients have been presented with repeated 'accidental' injuries

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

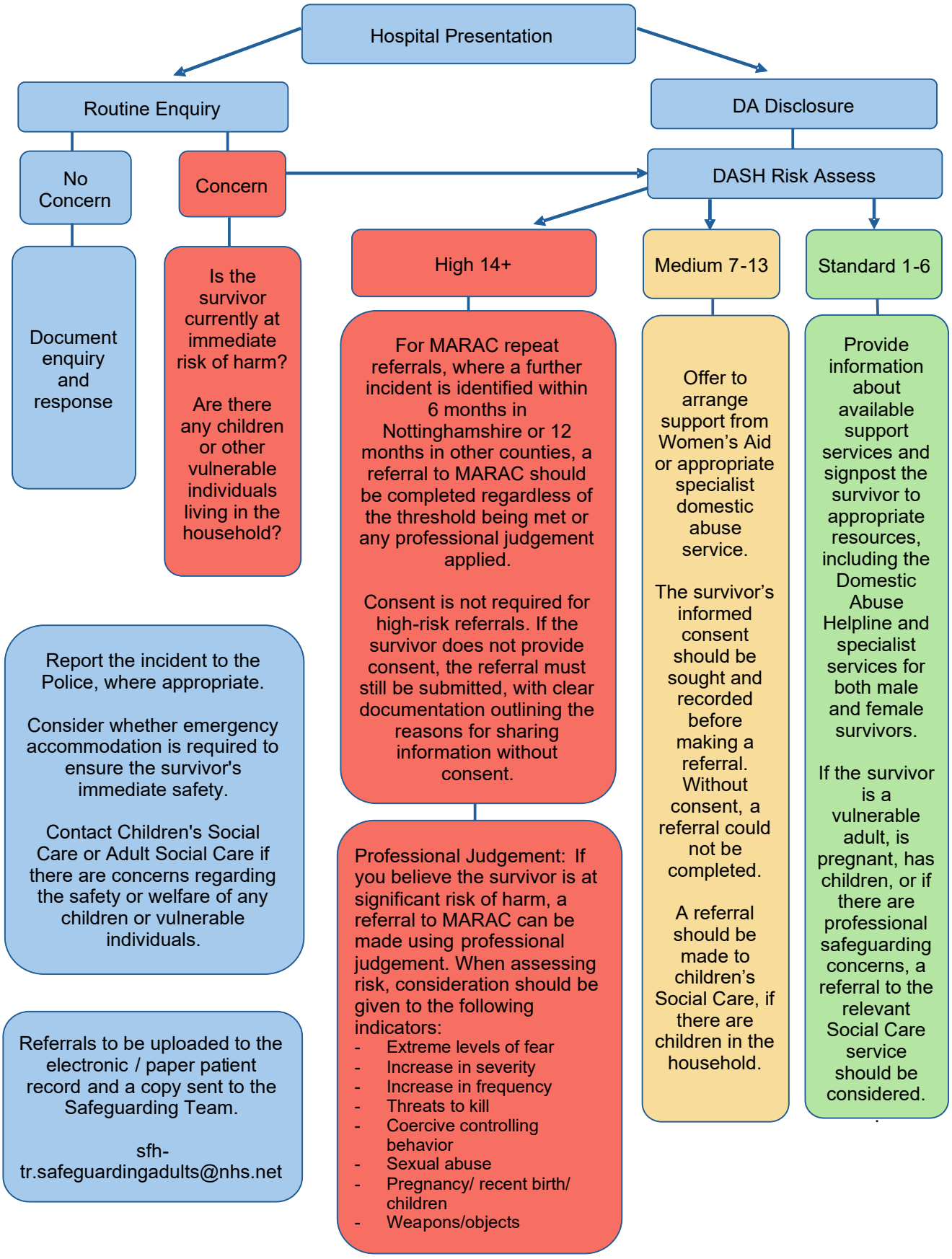
Whilst a child will respond differently to the abuse they have witnessed or experienced depending on their age, their personal resilience and support mechanisms, there is evidence that children suffer long term damage through living in a household where domestic violence and abuse is taking place even 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
- Behavioral and emotional disturbance
- Introversion or withdrawal
- Thoughts of suicide or running away
- Post traumatic stress disorder
- Anger, aggressive behavior and delinquency
- Assuming 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 - Archived Guidance)

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



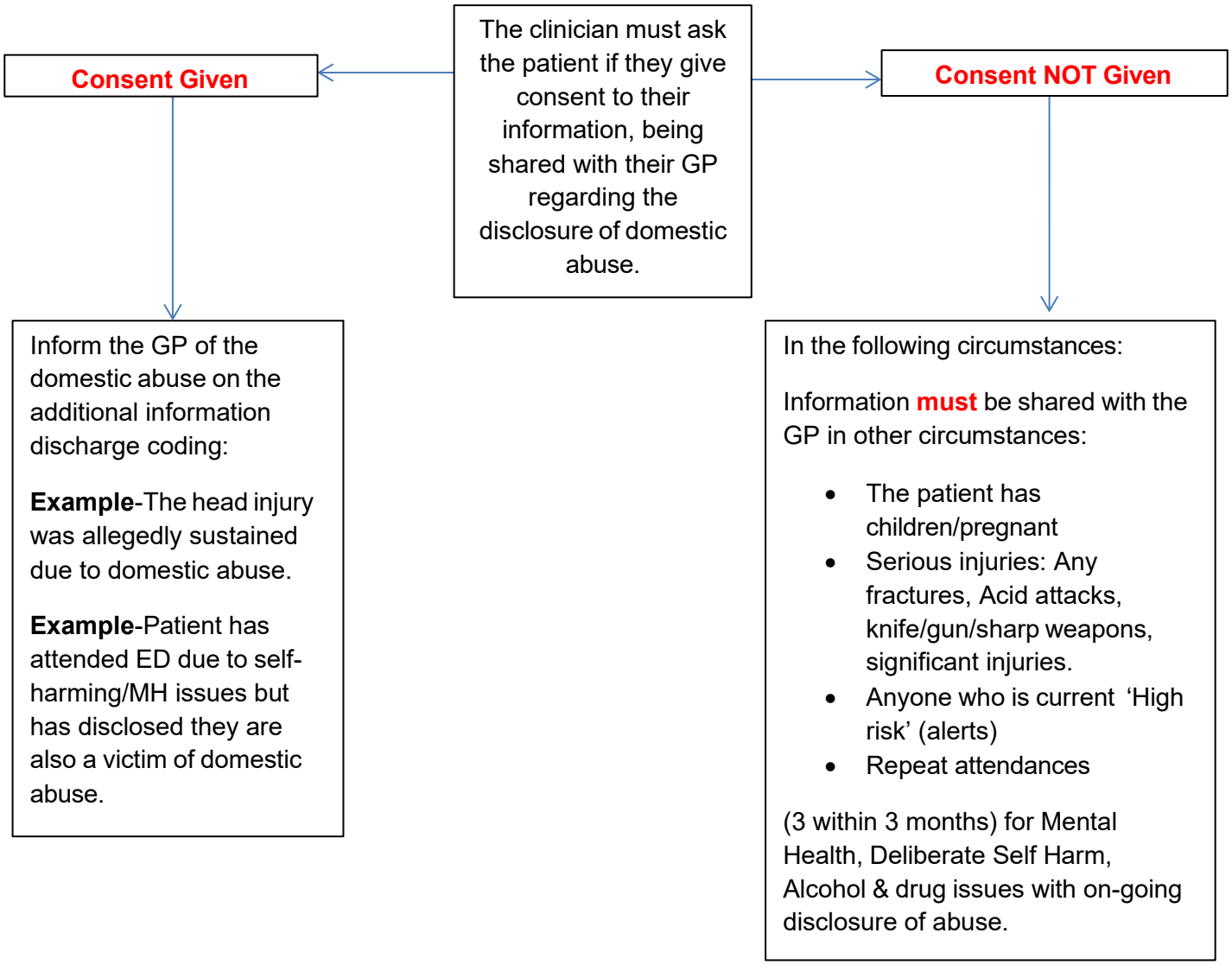
Appendix D - Local Domestic Abuse Organisations and Contact Numbers

Helpline Numbers	
For Female Survivors	
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
Derbyshire Domestic Abuse Helpline	Tel: 08000 198 668
Topaz Centre (Sexual Abuse and Violence)	Tel: 0330 223 0099
Nottingham Sexual Violence Support Services (NSVSS)	Tel: 0115 941 0440
Pet Foster Project (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	Tel: 0808 8000340
Broxtowe Women's Project	Tel: 01773 718555
Midlands Women's Aid	Tel: 0300 3020035 / 0115 925 7647
For Male Survivors	
Men's Advice Line Help and support services for heterosexual, gay, bisexual, and transgender male survivors of domestic abuse and violence.	Tel: 0808 8010327 www.mensadviceline.org.uk
Victim Support Supports standard and medium risk male survivors of domestic violence and abuse	Tel: 0808 1689 111
GALOP Specialist support for lesbian, gay, bisexual and transgender (LGBT) people experiencing domestic violence	Tel: 0800 999 5428
Equation – support for male victims (Monday - Friday 9:30-4:30)	Tel: 0800 995 6999 helpline@equation.org.uk
For Male/Female Perpetrators	

Respect Phoneline Help and Information for male and female perpetrators.	Tel: 0808 802 4040 www.respectphoneline.org.uk Email: info@respectphoneline.org.uk
Forced Marriage	
Forced Marriage Unit	Tel: 020 7008 0151
Karma Nirvana Helpline	Tel: 0800 5999 247
FGM	
NSPCC 24hr FGM Helpline	Tel: 0800 028 3550

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	Tel: 0115 941 4279
Shine (Housing related support)	Tel: 0115 822 0833
Umuada Refuge	Tel: 0115 666 6749
Childline	Tel: 0800 1111
Shelter	Tel: 0808 800 4444
Framework Housing Advice Helpline	Tel: 0115 841 7711

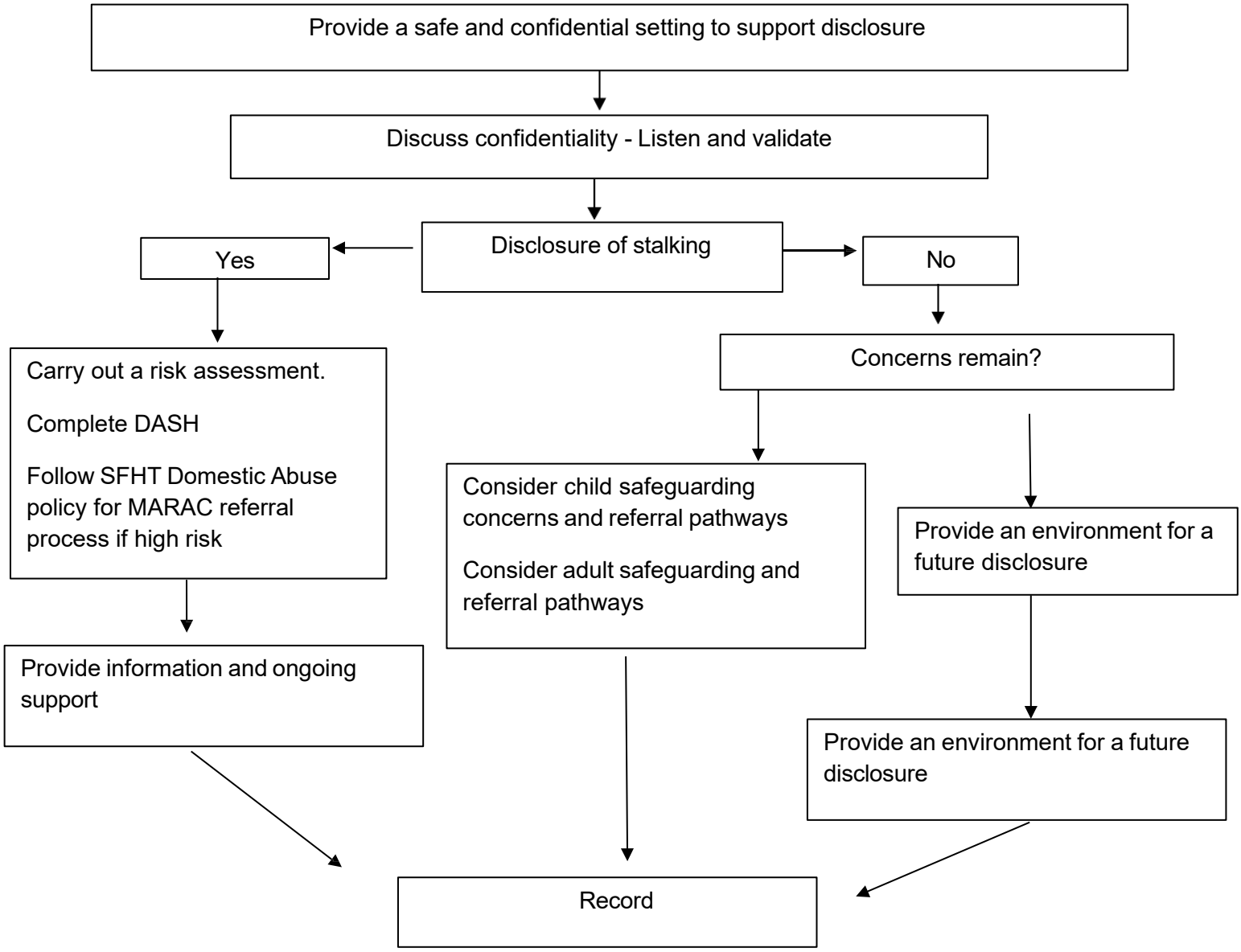
Appendix E - PROCEDURE FOR A DISCHARGE LETTER TO A GP FOR PEOPLE WHO HAVE ATTENDED THE EMERGENCY DEPARTMENT/ UTC AND HAVE DISCLOSED DOMESTIC ABUSE



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 0203 866 4107 www.paladinservice.co.uk

The Cyber Helpline www.thecyberhelpline.com

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)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Yvonne Pabi-Dumba	**Date of EIA completion:** 08/07/2026
Department: Safeguarding & Vulnerabilities	**Division:** Corporate
Name of service/policy/procedure being reviewed or created: Domestic Abuse Policy (Patients) v3.0	
Name of person responsible for service/policy/procedure: Yvonne Pabi-Dumba, Named Professional for Safeguarding Adults	
Brief summary of policy, procedure or service being assessed: This policy outlines the Trust's approach to identifying, responding to, and supporting patients affected by domestic abuse. It provides guidance to staff on recognising signs of abuse, undertaking appropriate risk assessments, making referrals, safeguarding adults and children, and working with partner agencies to ensure the safety and wellbeing of patients.	
Please state who this policy will affect: Patients or Service Users, Carers or families, Commissioned Services, Communities in placed based settings, Staff, Stakeholder organisations	

Protected Characteristic	Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)	Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.
Race and Ethnicity	No	The Domestic Abuse Policy provides equitable care and access to support for all patients regardless of race, ethnicity, gender, age, religion or belief, disability, sexuality, gender reassignment, marital status, civil partnership status, socio-economic background, or social deprivation. The Domestic Abuse Policy applies to all patients aged 16 years and over and is designed to ensure that individuals are treated fairly and without discrimination. The policy also recognises that pregnant and postnatal patients may be at increased risk of domestic abuse and includes appropriate safeguarding considerations to support their specific needs. The policy acknowledges and respects the rights of individuals who are married or in civil partnerships, ensuring that all patients receive consistent, inclusive, and person-centered care. Data and information used to support this EIA:
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No	

Gender Reassignment	No	• 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 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 behavior of alleged perpetrators
Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	No	

		• 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: (2026)

What consultation with protected characteristic groups including patient groups have you carried out?
The policy acknowledges the needs of patients who disclose domestic abuse, or where there are concerns regarding adults and/or children, while also requiring acute healthcare interventions. To ensure compliance with current legislation and best practice, the policy was shared with senior medical and mental health colleagues for consultation and feedback to ensure it effectively meets the needs of vulnerable patients

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.

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive

Low

If you identified positive impact, please outline the details here: The policy promotes equitable access to support and safeguarding interventions for all patients affected by domestic abuse, irrespective of protected characteristics. It strengthens the Trust's response to domestic abuse, supports survivors of domestic abuse and ensures compliance with current legislation and national guidance.

Signature: Y.P-Dumba *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date: 8th July 2026
Please send the complete EIA form to the People EDI Team for review. **Please send the form to: sfh-tr.edisupport@nhs.net**